

INDEPENDENT NEUROLOGY INQUIRY

Report
June 2022

Volume 4

www.neurologyinquiry.org.uk

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CHAPTER 14 – BLOOD PATCH PROCEDURES

Introduction:

- 14.1 The Inquiry is required to evaluate the corporate governance procedures and arrangements within the Belfast Trust during the period November 2016 until May 2018 in relation to the circumstances which led to the recall of patients. Questions over the appropriateness of the diagnosis of two patients with spontaneous intracranial hypotension (“SIH”) and their subsequent treatment by blood patch procedure were raised with the Trust in December 2016. Concerns around this diagnosis and treatment were a key factor in the events, which led to the recall of patients.
- 14.2 The Inquiry Panel is also required 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. Given that concerns around SIH and blood patch procedures did ultimately lead to an intensive investigation into Dr Watt’s practice by the Trust, the Inquiry is obligated to consider whether there were circumstances in relation to either which should have resulted in that investigation and its consequences occurring earlier than it did.
- 14.3 The media and two BBC Northern Ireland¹ Spotlight programmes have brought to the attention of the public, broader concerns about the number of blood patch procedures that were being carried out within the Belfast Health and Social Care Trust (“the Trust”). The Inquiry did not encounter any evidence, which suggested that blood patch procedures were undertaken on the premises of either the Ulster Independent Clinic (“UIC”) or the Hillsborough Private Clinic (“HPC”) where Dr Watt saw private patients.
- 14.4 There are several causes of intracranial hypotension, sometimes resulting from interventional medical procedures, such as lumbar puncture and epidural anaesthesia. As its name implies, SIH occurs without any obvious cause. The World Health Organisation’s *“International Classification of Diseases”* defines intracranial hypotension as: *“a single pathological entity of diverse origin. Usually, it is characterised by an orthostatic headache, one that occurs or worsens with upright posture”*.
- 14.5 The investigation and management of SIH in respect of individual patients can be complex and is not a matter for the Inquiry. However, it may be treated with the

¹ The programmes were aired on 19th November 2019 and 28th September 2021 respectively.

introduction of autologous (“the patient’s own”) blood into the cerebrospinal fluid (“CSF”) in the hope that the blood will clot and ‘patch’ any hole through which CSF is leaking.

- 14.6 By common assent, SIH is a relatively rare condition. The issue within the Trust is that whilst the Inquiry was told by many neurologists that it is an uncommon condition, Dr Watt made the diagnosis with increasing frequency and treated the patient with a blood patch, and often with a series of blood patch procedures. The Inquiry has not been able to ascertain the precise number of patients diagnosed or the number of blood patch procedures performed by Dr Watt. The evidence obtained does, however, reveal an increase in the number of blood patch procedures, which is, by any standards, unusual and dramatic.
- 14.7 Dr Thomas Peukert, was asked by the Clinical Director Dr John Craig in December 2016 to oversee the practice of Dr Watt in this area². His evidence was that he relied upon the diagnostic criteria set out in a paper authored by W I Schievink and others in May 2008³. Dr Schievink has authored several papers on this subject and had also previously stated that: “*SIH is an increasingly recognised cause of new daily persistent headaches*”. As someone who had developed a sub-specialty in headaches, Dr Peukert was in a position to analyse the relevant literature. Dr Schievink had suggested that the incidence of SIH was higher than had previously been understood. The diagnostic criteria suggested by Dr Schievink are set out below for ease of reference:

Criterion A, demonstration of a spinal CSF leak (i.e., presence of extrathecal CSF),

Or, if criterion A not met:

Criterion B, cranial MR imaging changes of intracranial hypotension (ie, presence of subdural fluid collections, enhancement of the pachymeninges, or sagging of the brain), and the presence of at least one of the following:

- (i) Low opening pressure (≤ 60 mm H₂O);
- (ii) Spinal meningeal diverticulum;
- (iii) Improvement of symptoms after epidural blood patching;

² The precise wording of the restriction was not seen by Dr Peukert but is contained in a letter from Dr Jack to Dr Watt on 13th December 2016. In summary:

“1. When presented with any NEW cases which you consider is indicative of a diagnosis of spontaneous intracranial hypotension, you must discuss the diagnosis and treatment plan with a colleague at consultant grade; the details of who this will be provided to you urgently.

2. When presented with any REVIEW case, which you have previously considered is indicative of a diagnosis of spontaneous intracranial hypotension, you must discuss the treatment plan with the colleague at 1 above”

³ Diagnostic Criteria for Spontaneous Spinal CSF Leaks and Intracranial Hypotension: Schievink et alia AJNR Am J Neuroradiology 29:853–56 May 2008.

Or if criteria A and B not met:

Criterion C, the presence of all of the following or at least 2 of the following if typical orthostatic headaches are present:

- (i) Low opening pressure (≤ 60 mm H₂O);
- (ii) Spinal meningeal diverticulum, and
- (iii) Improvement of symptoms after epidural blood patching.

14.8 It is not for the Inquiry to determine whether individual diagnoses were correct or the treatment appropriate. However, in this regard, the Inquiry notes the findings of Dr Peukert, which are set out below, and the conclusions of the RCP in its report⁴. The most appropriate way to assess whether a concern should have been triggered and an earlier investigation mounted, is to consider the behaviour of individuals and groups of individuals over time. It is also a matter for the Inquiry to comment on whether this remarkable pattern should have raised concerns and resulted in a detailed review of the situation. In this chapter, there is a specific focus on governance and management by the Trust of the situation that developed between 2014 to 2016.

Neurologists' Experience of SIH:

14.9 The Inquiry received evidence from all consultants and registrars in neurology regarding their experience of the condition of SIH, which may, in some circumstances, require a blood patch procedure. The overwhelming preponderance of the evidence was that the condition was observed infrequently and, for some neurologists, only on discrete occasions throughout the course of their careers.

14.10 Dr Thomas Peukert had developed a sub-specialty in headaches by the time he gave evidence to the Inquiry but was clear that he rarely came across the condition. In his written statement dated 9th November 2018, Dr Peukert recorded:

Although I do lead a headache clinic it is relatively rare for me to diagnose and treat patients for spontaneous intracranial hypotension headaches. At the headache clinic I am more likely to come across such patients and, as such, more likely to have experience in carrying out this procedure than other Neurologists in the Trust. In all, however, the procedures which I have been involved in are probably still in the single figures.

⁴ The Royal College of Physicians had noted that Dr Watt's approach to blood patching was: "well outside the acceptable range and raised serious questions about his understanding of the relevant application of this therapeutic technique". The report noted that the frequency with which he recommends blood patching is far beyond any practice the clinical reviewers have come across.

- 14.11 Dr John Craig, the Clinical Director for Neurosciences, also viewed the condition as an “*uncommon disorder*”. On 20th December 2018, he stated to the Inquiry Panel:

I would consider this to be an uncommon disorder in neurology. I’ve certainly seen cases of it over the years, and, I mean, this year, probably I’ve seen one case and there’s been two other people in the ward with it with very unusual presentations of it. So, it is reported to present in very unusual ways. I’d certainly referred Dr Watt cases that I thought had it, that radiologically had it, that he did an epidural blood patch on and they got better and, you know, was grateful for him being able to do that.

- 14.12 Asked whether all neurologists would easily recognise the condition, Dr Craig stated:

I think that all of us should be able to make the diagnosis in standard cases. There are agreed criteria, but, for the most part, it’s, “I get a headache when I stand up. It goes away when I lie down”. You may have some other symptoms — ringing in your ears, visual disturbance — and that will be supported by MR imaging. So, for the vast majority of cases — and, I suppose, it’s like all of medicine — making diagnoses for things like that, any generalist neurologist or any neurologist who’s board-accredited — call it what you will — should be able to make the diagnosis in the vast majority of the cases ... From a clinical perspective, I would not have thought that Dr Watt’s ability to diagnose this for the vast majority of cases was any different from the rest of us. Clearly, when you get expertise in a condition, you sometimes end up seeming to do the wrong thing but for the — because you’ve seen it before; it’s been described, it’s — not everything does it like it says on the tin, I suppose. So he wouldn’t have had any more — he shouldn’t have had any more skill, and he wouldn’t have had any additional training that I’m aware of that would have given that.

- 14.13 On 1st February 2019, the Clinical Lead for Neurology, Dr Gavin McDonnell, told the Inquiry Panel that SIH was a condition he had “*rarely seen*”.

- 14.14 On 2nd May 2019, Dr Stella Hughes recalled preparing a presentation on the subject in 2009 for the Irish Neurological Association meeting:

I remember actually looking at a series of cases in about 2009 for the Irish Neurological Association meeting. I had sent round an email to all of the consultants asking, “Do you have any cases of spontaneous intracranial hypotension? We’d like to put them together”, and we did have maybe nine cases or so to present as a poster at that meeting.

I would’ve been careful in taking a history from a patient with headache that I wasn’t missing a postural feature to it. I did come across what, I felt, were consistent with SIH two cases during my time doing rapid access neurology

clinics or 'RANC's, and I had referred both of those patients to Dr Watt. I suppose those are two cases I came across within a one-year period, really, doing those clinics.

- 14.15 Dr Paul McMonagle agreed that he did not come across the condition of SIH often, but explained in his evidence of 25th March 2019:

I think it would be accepted that we've as a body become more and more aware of this notion of spontaneous intracranial hypotension in recent years. I'm sure that I came across cases and did not diagnose them... The difficulty is that there are test that you use to diagnose it which should be reliable but yet they don't pick up all the cases. You've probably heard this, but the MRI scan stuff is diagnostic in maybe 80% of people.

When it comes to what Michael [Watt] was doing, I think that he was, you know, hearing the hooves and seeing zebras... He was basically seeing it everywhere. Clearly, and I think, playing on that uncertainty about the MRI reliability and the lumbar puncture reliability to justify diagnoses without there being objective evidence of it.

- 14.16 Dr Stephen Hunt had slightly more experience of the condition. In his evidence of 2nd May 2019, he told the Inquiry Panel:

I wouldn't say rare. It's uncommon ... In the last year, I have had three patients with spontaneous intracranial hypotension; one of whom, after a week's deliberation as an inpatient in the Royal hospital with two second opinions from other colleagues, we proceeded to do the thing, partly because of all this ... So, in any year, I probably would diagnose it [SIH] two to five times.

- 14.17 Dr Hunt was, however, clear that he would ordinarily expect to see objective evidence of the condition:

I've yet to diagnose this entity in somebody without objective evidence of it.

- 14.18 Asked by the Inquiry Panel as to whether it was possible for a patient to have the condition of SIH in the absence of objective evidence, Dr Hunt stated:

Can somebody have intracranial hypotension but have no features of it on an MRI scan? The answer is probably yes. Is that a common occurrence? No, it is not. Would you simply

Say, "Oh, we see this. This happens. Sure just get on with it"? No, I think it would deserve a bit of further thought and discussion with at least another person before you would do anything about it.

- 14.19 Both Dr Aidan Droogan and Dr Ferghal McVerry regarded the condition as “*very rare*”. Dr Droogan told the Inquiry Panel on 10th April 2019:

I had one patient about 15 years ago ... we did a blood patch, and it had a big beneficial impact on her. So, I had that one case that sticks in my mind. Well, post-lumbar puncture headache: some patients do develop a severe headache which doesn't settle beyond two weeks. That has been very rare in my experience. I may have maybe once arranged a blood patch ...

- 14.20 Dr Mark McCarron, like Dr Hunt, had seen a few more cases in his career over a period of 16 years. In his evidence of 13th May 2019, he told the Inquiry Panel:

I would think between 10 and 12 ... The majority of them would've been corroborated by imaging, particularly as time went on. It started to be recognised the neuro-imaging features of it to the extent that you no longer had to do a lumbar puncture to prove the pressure was low.

Consultants' Experience of Blood Patch Procedures:

- 14.21 While the diagnosis of SIH was relatively rare, it was also the case that few consultants had either carried out or recommended a blood patch procedure because of the incidence of the condition.

- 14.22 In his evidence of 15th January 2019, Dr John McKinley told the Inquiry Panel that he had carried out a few blood patch procedures while working under Dr Raeburn Forbes in Craigavon, but had seen less than 5 since being appointed as a consultant:

I think less than five since I've been appointed as a consultant. Now, I've never — I've made a diagnosis of intracranial hypotension. I can think of one gentleman who was lifting a goalpost and then. You know, I've come across people with post lumbar puncture headaches. My management is entirely conservative. So, I've never referred anybody for a blood patch, because I'm of the opinion that, if it was me, I would want to try bed rest.

- 14.23 Dr Ferghal McVerry stated to the Inquiry Panel on 1st May 2019:

It's something that I've thought of on a few patients in the last four years — people that have had true spontaneous intracranial hypotension. But the natural history is usually one for settling down. So, therefore, I haven't directly asked for a blood patch on anyone. I've considered it in probably one or two and, thankfully, haven't had to go down that route. So, it's a rare — relatively rare thing to have to be done.

Frequency & Volume of Blood Patch Procedures:

- 14.24 The Inquiry received a significant volume of data and evidence from the Trust, which indicated not just a dramatic increase in the number of blood patch procedures from 2013 onwards, but a significant variation in the number of procedures carried out. It has proved impossible for the Inquiry or the Trust to identify precisely the number performed by Dr Watt.
- 14.25 A majority of blood patch procedures undertaken were what is known as ‘blind’ blood patches. This involved blood being injected into the lumbar spine, with the hope that blood would travel to the source of the leak and effectively ‘patch’ the hole. A minority of procedures were undertaken with the assistance of medical imaging techniques, namely CT and fluoroscopy. These procedures required the assistance of neuroradiologists and were undertaken with the intention of targeting the area where the leak was thought to be present.
- 14.26 The role of Neuroradiology, therefore, was discrete and focused on CT⁵ or fluoroscopically guided⁶ blood patch procedures. Dr Graham Smyth, Neuroradiologist, gave evidence to the Inquiry on 30th March 2021 and indicated that most image guided blood patch procedures undertaken were fluoroscopically guided, rather than CT guided. Of the 29 recorded blood patch procedures undertaken in Neuroradiology, to his knowledge only two patients had undergone CT guided procedures. This created some confusion given that all image-guided procedures were generally referred to as ‘CT guided blood patches’ by the Trust.
- 14.27 Dr Smyth’s evidence to the Inquiry indicated that the role of the neuroradiologists was not at the diagnostic stage, but in assisting the actual treatment of patients only. He, therefore, did not query Dr Watt’s diagnosis of SIH in a particular case referred:
- I suppose it was recognised that there were patients who were diagnosed to have the clinical syndrome and I was being told by [Dr Watt] – I had nobody else to tell me that he wasn’t a highly regarded neurologist – that he had diagnosed him with this condition, ‘would you care to give us a hand to find the level and it was ‘yes, yes’, I suppose more a courtesy than anything else’.
- 14.28 The problem that emerged was that those doctors in neuroradiology, who had been asked to assist Dr Watt, were relying on his earlier diagnostic decision. It is clear from Dr Smyth’s evidence, that the involvement of a neuroradiologist in the

⁵ CT (Computed Tomography) is a scanning technique, which uses X-rays and a computer to create a series of cross-sectional images of structures inside the body, including the internal organs, blood vessels and bone.

⁶ Fluoroscopy is a study of moving body structures--similar to an X-ray. A continuous X-ray beam is passed through the body part being examined. The beam is transmitted to a TV-like monitor so that the body part and its motion can be seen in detail.

procedure itself did not add security to the diagnosis, because the neuroradiologists did not see themselves as having a role in establishing or querying the diagnosis at that stage. The Inquiry Panel notes that at no point was there any question raised by neuroradiologists about the prevalence of SIH or the marked increase in associated blood patch procedures. Dr Smyth observed:

It might have been as time went on there might have been more that didn't have objective imaging evidence on their brain MRI, but it might have been there are some soft signs when we do the CT myelogram ... it is claimed or said in some studies that patients with intracranial hypotension have more [perineural cysts'], and then for those patients that might be because they have an underlying collagen disorder where their connective tissue is weak ... It may be that we said, 'there are two perineural cysts at this level', we reported that, for instance, and then Dr Watt might take that as, 'there's a level I will target because I've got it in my head that this patient clinically has this condition'.

Dr Smyth was asked by the Inquiry Chairman as to why Dr Watt approached neuroradiology:

Mr Lockhart QC: What criteria would he [Dr Watt] use when he comes to you?

Dr Smyth: I think it was those patients for whom several blind lumbar blood patches had failed, in his eyes, to – had either failed or had produced some temporary benefit and then he would come to us. That was my impression.

- 14.29 From the evidence obtained, and subject to the caveats expressed in Appendix 2, it appears that approximately 40 blood patch procedures⁷ were carried out by Dr Watt with other neuroradiologists using either the fluoroscopic or CT guided method.

Blood Patch Procedures within Neurology:

- 14.30 In April 2017, Ms Clare Lundy, then Assistant Services Manager for Neurosciences, sought to obtain statistics for the number of blood patch procedures undertaken within Neurosciences from 1st April 2012 to 31st March 2017. A search of the procedure code A.52.3 on the Patient Administration System ("PAS") by the Coding Department produced the following totals:

⁷ In a written statement dated 8th March 2021 Ms Lundy stated: "The position is that there were in fact 21 patients who received at least one radiology guided EBP connected to Dr Watt (either a CT guided EBP or a fluoroscopic guided EBP). Those patients had a total of 40 radiology guided EBPs between them.

Fiscal Year	Procedures
2012/2013	6
2013/2014	4
2014/2015	27
2015/2016	91
2016/2017	126
Total	254

14.31 This table hereafter is referred to as the “Coding audit”. Whilst the search period ran until 31st March 2017, the last recorded blood patch procedure in these statistics was in December 2016. The Coding audit does not record any blood patch procedures performed by Dr Watt, when he was subject to a restriction on this area of his practice or where he was working with any other neurologist or neurosurgeon, in the first three months of 2017. Of the 254 total, 22 procedures were linked to a consultant other than Dr Watt. Six of these were 6 different neurosurgeons; the other 16 were linked to 5 other consultant neurologists. The PAS, which was searched to provide this data, was not used to code procedures undertaken with radiology assistance.

14.32 By the time a Freedom of Information request was made by a neurology patient in August 2018, the Trust figures had altered. The figures given included 17 procedures prior to the 2012/2013 year and the comparative total was 226 blood patch procedures as compared to 254 identified by the Coding department.⁸

Year	Number of EBPs
2008	0
2009	4
2010	10
2011	3
2012	8
2013	6
2014	19
2015	72
2016	92
2017	29
Total	243⁹

⁸ The request also disclosed that there is ‘no protocol in place in Belfast HSC Trust’ and advised that ‘the need for epidural blood patch is based on clinical assessment supported by neuro-imaging’.

⁹ 226 between 2012 and 2017.

14.33 Further to a Section 21 notice¹⁰ issued by the Inquiry, the Services Manager for Neurosciences provided further statistics for blood patch procedures undertaken between 1st April 2010 and 31st March 2018. Of the total of 276 procedures, 11 of these procedures on 9 patients were performed by 6 other neurologists or neurosurgeons.

Blood Patch Procedures carried out in Neurology (Excluding Radiology):

Year	Blood patch procedures carried out in Neurology
10/11	3
11/12	2
12/13	6
13/14	4
14/15	31
15/16	91
16/17	136
17/18	3
TOTAL	276

14.34 The above table represents a search carried out on the PAS and excludes procedures carried out with radiology assistance. Following the setting up of the Inquiry, the Trust conducted a review of image guided blood patch procedures and identified 40 such procedures performed by Dr Watt. (see, [29] above) Therefore, on the Trust’s most recent analysis, 305 blood patch procedures were performed between April 2010 and 28th June 2017.

14.35 The Inquiry received approximately 30,000 emails in May 2020, following extensive searches of the Belfast Trust server. The Inquiry sought to calculate the number of procedures for which evidence could be found, independent of the Trust’s statistics. This was done with the assistance of the additional emails, the evidence of relevant witnesses and patient clinic letters. The true total is likely to be appreciably higher than the figure of 305 procedures provided by the Trust. At the end of the Inquiry investigation, it was still not possible to be certain or entirely accurate as to the number of blood patch procedures carried out by Dr Watt in the relevant time-period.

¹⁰ Section 21 of the Inquiries Act 2005 states that the Inquiry Chairman may by notice require a person to attend at a time and place stated in the notice to give evidence or produce documents.

14.36 In addition, various caveats and explanations need to be given in respect of the estimation of total blood patch procedures reached by the Inquiry¹¹. These are set out in detail in Appendix 2 at the conclusion of this chapter. The explanations, having been recorded, and a methodology adopted, the Inquiry compiled its own table as set out below.

INI EBP TABLE (June 2021)

Year	Number of EBPs
2011	2
2012	9
2013	2
2014	27
2015	114
2016	162
2017	32
Procedures involving radiological input	47
Total Blood Patches	348

14.37 It is apparent that over the course of at least four attempts to collate statistics for the number of blood patch procedures undertaken associated with Neurosciences, the Trust reached different conclusions on each occasion. Perhaps unsurprisingly, none of these matched up with the Inquiry’s best efforts to calculate the total number over the same period.

14.38 The Inquiry was able to identify the following factors which hampered the Trust (and the Inquiry) in accurately capturing the number of blood patch procedures undertaken in the Trust within Neurosciences and including Neuroradiology:

- (i) Blood patch procedures were performed by Dr Watt in numerous locations around the Royal Victoria Hospital site, including Ward 4E (neurology inpatients), Ward 4F (neurosurgery inpatients), Ward 2F (acute medical unit), the PTU (programmed treatment unit), the DSU (Day of Surgery Unit) and interventional radiology.
- (ii) Several patients had blood patch procedures but were inaccurately recorded by neuroradiology as having ‘myelogram’ or ‘CSF scintigraphy’

¹¹ For the avoidance of doubt the exercise carried out by the Inquiry was at its own initiative and was not scrutinised by the Belfast Trust prior to the conclusion of the evidence.

procedures. Mr Philip Frizzell, the then Superintendent Radiographer, and subsequently the Service Improvement Manager for Radiology, gave evidence that he had identified 3 such records, where he was aware the patient had undergone a blood patch procedure, rather than the different procedure recorded.

- (iii) The Inquiry Panel noted that patients who had undergone blood patch procedures were also recorded as having had lumbar punctures in or around the same time. Although that is possible, it raises the question as to whether some of these procedures were also inaccurately recorded as lumbar punctures.
- (iv) On several occasions, patients underwent blood patch procedures as inpatients on Ward 4E. In relation to these patients, some were admitted with a view to conducting a series of blood patch procedures, i.e., in the expectation that one or possibly two would be unsuccessful and the patient would require multiple procedures in a short period of time. When steps had been taken to prevent patients coming to Ward 4E as outpatients for a blood patch procedure, patients continued to be admitted for the procedure. As noted in Appendix 2, for the purposes of PAS coding, a patient only appears once against the procedure code for an inpatient stay, no matter how many blood patch procedures were carried out. The figures collated in April 2017 by the Trust against the code A.52.3 (which excludes image guided procedures) do not, therefore, capture multiple procedures in one admission.
- (v) The Inquiry has identified further issues with recording of inpatient procedures. For example, patient INI 464 underwent 4 blood patch procedures as an inpatient over the course of a month between November and December 2013, followed by an image guided procedure some time before 10th March 2014. In the Coding audit collated by the Trust, for that period, she is not recorded as having undergone any blood patch procedures.
- (vi) The chaotic nature of arrangements for procedures done on Ward 4E is set out in detail below, and this clearly contributed to the inability of Trust staff to capture all the procedures undertaken. Sister Vanessa Boyd, in her evidence to the Inquiry Panel of 1st March 2020, described the difficulties in dealing with the increasing number of patients who were attending for a blood patch procedure without having been booked in:

Yes, it was chaotic. It was a poor experience for the people who were coming for it, and, if it was to be that they were coming to the unit, then they needed to have a structuring process to be able to manage them in a way which was professional-looking. Because it wasn't. It

felt unprofessional at the beginning, because they would've just — you know, maybe on a Monday morning, you might have come into work and there would've been Dr Watt with possibly two or, maybe, three people for blood patches that day.

- (vii) Many of the patients who turned up appear to have been private patients of Dr Watt and details of their consultations within the independent sector would not be part of their NHS medical notes. Further, the Inquiry is aware from an investigation into Dr Watt by Business Services Organisation Internal Audit that he did not always comply with the necessary record keeping for transferring private patients to the NHS. In the view of the Inquiry Panel, this factor alone makes it highly unlikely that the Trust has access to accurate statistics for blood patch procedures.
- (viii) In addition, Sister Sterling, who ran the acute medical unit on Ward 2F, gave evidence that Dr Watt would just “turn up” in Ward 2F with a patient to undertake a procedure and she would “try to catch him” to identify the patient and book them in.
- (ix) The difficulties in accurately recording other blood patch procedures undertaken in the PTU were known to the Trust, as evidenced by an email of 6th April 2016 from Darren Browne, the Clinical Coding Manager, who wrote to a colleague and noted:

We are having real issues with discharge forms not being completed for day-cases in PTU. Many patients do not have forms completed for their day-case. Robert is having to look at the admission reason on PAS and code that as the procedure using the assumption that if the patient was admitted and discharged then they attended and had the procedure done. This will lead to errors and inaccuracies as sometimes the procedure will not actually have been performed and could have been cancelled for any number of reasons. Just this week a patient was coded as above and it was only as we were contacted by Dr Watt's secretary we found out that the patient was cancelled the day before they were due to attend and the patient should not even have been admitted on PAS. We had coded it as an epidural blood patch as that was what the patient was due to have done if admitted. Even if a procedure is actually done our diagnostic and procedural information will be very poor.

Due to the volume of patients going through PTU, and the lack of information for us to use instead if a day case form is not completed, we have little choice to do as we are doing and accept that there will be errors. If we don't there will be hundreds of uncoded episodes in PTU. I know you can only pass this along to the clinical staff in PTU

as it is their responsibility but from a basic Governance perspective our current practice to code these episodes is very poor.

- 14.39 A number of patients gave evidence to the Inquiry that their medical notes did not record all of the blood patch procedures that they had undergone. This was of concern to the Inquiry Panel, as patient medical notes should be a complete and accurate record of the treatment and care provided. With the consent of four relevant patients INI 106, INI 401, INI 414 and INI 415, the Inquiry obtained their medical notes and reviewed them. The Inquiry Panel had no reason to doubt the evidence of the patients as to the number of blood patch procedures that they had received or the dates for same.
- 14.40 Upon review of the relevant medical notes, the Inquiry discovered evidence substantiating the fact that the procedure was planned or had gone ahead (for example, booking emails or subsequent clinic letters), but in respect of three of the four patients the Inquiry was unable to locate a relevant entry in their medical notes recording the blood patch procedure being performed. It, therefore, appears that in these cases the relevant patient medical notes may not provide a complete and accurate record of all blood patch procedures performed by Dr Watt. The Inquiry Panel did not consider it necessary or appropriate to take any further steps to establish the extent to which this trend reflects the position across all of Dr Watt's blood patch patients.
- 14.41 The Inquiry also heard evidence both from Dr Peukert and the daughter of patient INI 490, on whom Dr Watt had performed three blood patch procedures which were unrecorded. Some evidence relating to one of these procedures was found in the email trawl undertaken by the Inquiry. The patient's daughter gave clear evidence that her mother had undergone three blood patch procedures in the PTU under Dr Watt's care. While Dr Watt had seen the patient privately some years before, the patient's daughter understood this to be an NHS takeover of care from the patient's neurosurgeon to Dr Watt. Dr Peukert could find no record in the patient's notes of her having undergone any blood patch procedures. As noted by Dr Peukert, the patient was not subsequently recalled by the Trust because there was no record of her having undergone a blood patch procedure (and she had not attended Dr Watt privately since 2011 so was not picked up by any independent sector provider).
- 14.42 The absence of records in medical notes relating to blood patch procedures undertaken was not surprising to the Inquiry Panel in light of evidence received from Trust staff as to the, often, chaotic arrangements for the procedures. Dr Watt's secretary usually obtained the patient's notes for the procedure, so if she was

unaware the patient was undergoing a blood patch procedure, she would not have provided Dr Watt with the notes to make a record. In her evidence to the Inquiry Panel on 2nd September 2019, she explained some of the problems she experienced in getting notes to the ward:

Mr Lockhart QC: And were there any difficulties for you in trying to arrange it at all?

Dr Watt's secretary: When the ones that just turned up to the ward, I like a chart to be there ... So, there was running about trying to get stuff up to the ward for patients that I didn't know nothing about.

Mr Lockhart QC: And how did that occur?

Dr Watt's secretary: He could've just saw the patients and just says, "Come for a blood patch". To me, that's just the way they started.

Mr Lockhart QC: ... her [Sister Vanessa Boyd's] impression of you in particular was that ... this was putting you under enormous pressure. What was your view of it?

Dr Watt's secretary: It was. At the time, it just felt as if the list was getting bigger and bigger. The patients, when they did get a blood patch, they sometimes had to come back for a couple. Like, it wasn't as if they just got a blood patch and then that was them finished. They got a couple of blood patches. So, there wasn't really much space for the patients. Like, with regards to appointment times.

14.43 In a written statement provided by Ms Clare Lundy on 8th March 2021, Ms Lundy stated:

Similarly, I have come across a small number of patients ... where a patient did have an EBP, but it was not coded on the system. The errors do not affect the patient's treatment, because the actual medical records for the patients are accurate; but it does mean that the statistical data that I use can have some errors. My experience is that the data I can provide is highly reliable, and that the number of errors will be very small, but it also means that I cannot say that it is absolutely 100% correct.

14.44 The implication of Ms Lundy's evidence is that erroneous data on the Trust system does not pose a risk to patient safety, as all procedures were ultimately properly recorded in the patient's notes. The Inquiry concludes that the Trust is not able to give such an assurance as all procedures were clearly not recorded in the medical notes. Despite intense efforts by various individuals, and especially Dr Watt's secretary, the reality was that the system in place did not accurately record the precise number of blood patch procedures and repeats undertaken by Dr Watt. This represented not

just a patient safety issue but a significant governance and management failing. The Trust must first know that there is a governance issue which needs to be addressed and secondly it must do something about the problem.

The Number of Blood Patch Procedures Carried out on an Individual Patient:

- 14.45 Neurologists were asked by the Inquiry Panel about their experience of the frequency of blood patch procedures. It became apparent that some patients were undergoing numerous blood patch procedures when the result obtained with earlier procedures was regarded as inconclusive. Commenting on frequency, Dr Peukert stated in his evidence to the Inquiry Panel of 12th November 2018:

I wouldn't do it five times. I don't know what the papers say. I would do it three times and then leave it at that. Then you maybe want to look more in detail where the leak is and maybe more fancy tests. You can, for example, do a myelogram, so you can inject contrast in the CLF to see if it leaks, but by doing this you increase the risk of making the headache worse. But when you know then it is leaking from high up in the neck you can do a target blood patch there either with blood or with glue.

- 14.46 In relation to the number of repeat blood patch procedures that a consultant would carry out, Dr Craig stated on 19th December 2019:

I think, if you give anybody a treatment repeatedly and it doesn't work, you should really reconsider whether you've got the diagnosis right and you're offering the right therapy.

- 14.47 Dr McMonagle, who had referred a patient to Dr Watt, told the Inquiry Panel on 25th March 2019:

... In 2017 after [INI 117] had had 3 blood patches over around 8 months ... her mum was then on the phone saying, you know, she felt something give, the headaches came back, the mobility dropped off, you know, "Can you do another one?", and, at that stage, I said, "Look, I really don't know. This is beyond anything that I've done before or come across before".

- 14.48 In evidence to the Inquiry Panel of 8th January 2020 Dr Karen Doherty, stated:

I think, usually, if they're going to work, they work after the first one, usually. People don't usually get multiple blood patches. It would make me reconsider the diagnosis if you were thinking they needed further and further ones for effective treatment of a low CSF state.

- 14.49 On 10th March 2014 at the request of Dr Watt, Dr Stella Hughes (then a registrar) presented the case of patient INI 464 to the Neurosciences Grand Round. (INI 464 was a patient of Dr Watt at the time) The presentation recorded the patient as having undergone '4 epidural blood patches Nov/Dec 2013' with 'no symptomatic relief', followed by a later targeted blood patch procedure with short lived relief of headache. The management plan was for repeat blood patch procedure that week.
- 14.50 Dr Paul Conn was INI 464's GP and had previously raised concerns with Dr Donagh MacDonagh in 2012/2013 regarding a number of his patients under the care of Dr Watt. The detail in respect of the interaction between Dr Conn and Dr MacDonagh is set out in the Concerns chapter. In relation to this specific patient, Dr Watt had written to Dr Conn in 2013 as follows:
- Over the past month she has had 4 epidural blood patches. Unfortunately, they have made absolutely no difference. I have now arranged an urgent MRI of the remainder of her spine to look for a CSF leak. I will also arrange for her to be admitted urgently for this. I will also arrange for her to be admitted urgently for this as her condition has deteriorated in recent weeks and she is now unable to stay upright for any length of time.
- 14.51 Dr Conn, commenting on this, stated to the Inquiry Panel in his evidence of 30th October 2018:
- I have a patient who, you know, "over the past month she has had four epidural blood patches", we were kind of "wow", you know? This was a lady who presented with headaches. Unfortunately, they have made absolutely no difference and there was no evidence of any CSF leak.
- ... I mean we did have concerns. There was no doubt we had concerns ... It seemed that he was over-diagnosing and over-treating.
- 14.52 Notwithstanding the evidence about repeat blood patches none of the doctors known to be present at the Neurosciences Grand Round meeting considered the case to be in any way remarkable or memorable. Dr Craig, who was not present, described his impression of his colleagues' perception of the presentation as a 'textbook case'. In view of the consensus from other consultants that multiple blood patch procedures were both very rare and of questionable effectiveness, the Inquiry Panel found the lack of curiosity or challenge from consultant colleagues surprising.
- 14.53 On the basis of the Trust figures for blood patch procedures, in some cases, patients were receiving up to 6 procedures within a 3-month period. In one case, a patient underwent 11 blood patch procedures. The figures identified by the Inquiry indicate the number of Dr Watt's patients having 5 or more blood patch procedures was

well into double figures. This does not seem to have been picked up on by other consultant colleagues. It may be that his colleagues were not aware of the prevalence of repeat blood patches, but it appears unusual to the Inquiry that no questions were asked, or further information sought. While it is the case in the literature that a patient suffering from a spinal leak can sometimes benefit from more than one blood patch procedure, the numbers of repeat procedures are still extraordinary.

Neurosciences Grand Round:

14.54 The Neurosciences Grand Round (referred to above) was a weekly educational meeting in the Belfast Trust to be attended by doctors working within Neurosciences. Neurologists employed by other Trusts attended where possible. Junior doctors and medical students attended as and when they were available. Dr Stella Hughes on behalf of Dr Watt presented to the Grand Round on the topic of SIH in March 2014 and in February 2016. Evidence from Dr Watt's appraisal in 2017 also indicates that a further presentation to the Grand Round took place in or about March 2017.¹² This would imply that Dr Watt, therefore, discussed cases of SIH on 3 separate occasions at the meeting. According to a statement submitted by Dr Gavin McDonnell to the Inquiry, there were normally 30-50 persons present at the Grand Round. The Inquiry Panel noted from the evidence of all the neurologists that only a small number could recall or had evidence of having been present at one or any of the presentations given by Dr Watt or those registrars presenting on his behalf. The evidence indicated that the following consultants and registrars were definitely present:

at the March 2014 meeting:

- (i) Dr Michael Watt.
- (ii) Dr Stella Hughes.
- (iii) Dr Ingrid Hoeritzauer.
- (iv) Dr Carolynn Doherty.
- (v) Dr Orla Gray.
- (vi) Dr Mark McCarron.
- (vii) Dr Paul McMonagle.

at the February 2016 meeting:

- (i) Dr Ellen Campbell.
- (ii) Dr Michael Watt.
- (iii) Dr Aidan Droogan.
- (iv) Dr Paul McMonagle.

¹² In the Case Review Structured Reflective template, Dr Watt discusses a patient that he has taken over from Dr Paul McMonagle. Lumbar blood patches had taken place in June 2016 (twice), November 2016, February 2017 and March 2017. Dr Watt indicated that the patient had been presented at the neurosciences meeting.

at the March 2017 meeting:

- (i) Dr Michael Watt.
- (ii) Dr Catherine Donaldson.
- (iii) Dr Collette Donaghy.
- (iv) Dr Tom Esmonde.
- (v) Dr Karen McKnight.
- (vi) Dr Karen Doherty.
- vii) Dr Paul Mc Monagle.
- (viii) Dr Stephen Barr.

- 14.55 In her evidence to the Inquiry Panel, Dr Hughes was asked about the presentation on behalf of Dr Watt to the Grand Round Meeting on 10th March 2014:

Well, I can't be sure, but Dr Watt tended to recruit a registrar to help with his neurosciences grand round at short notice. I think he'd admit that fully himself. He tended to look at the rota for the grand round on a Monday, and he would often say to you on the ward round, "I'm actually doing a meeting tomorrow. Can you present a case?" which I would've readily agreed to. So, the particular patient, I think, was an inpatient at the time, so, normally, that's how we generate cases for the meeting: perhaps, an interesting or complex patient on the ward and we'd do a clinical summary and ask the radiologist to present their MRI quite often as well on the day.

- 14.56 Dr Craig was clear that he was at neither of the meetings in 2014 and 2016, but he was able to tell the Inquiry:

Dr Watt had presented to us at a meeting in 2014. He got somebody to do it on his behalf — a registrar — but there's a — he was there. There was a case presented, which is like a textbook case in terms of, "These are the diagnostic criteria. These are the MRI criteria". So, you know, we're there. We don't know much about this condition. We're learning about it from one of our colleagues who's presenting, and, as I say, we had referred some cases in, but, at some point in time, clearly, you know, looking back, there should've been a, "Let's stop here as a group and interrogate this.

- 14.57 Dr Craig also noted that the consensus from the neurologists who attended the meeting was that it was a helpful presentation. Colleagues had indicated that they did not know much about the area of SIH. As discussed above, the Inquiry obtained access to the actual presentation. The case history described a severe orthostatic headache, which is what neurologists agree is part of the classic presentation for SIH. The investigations noted an MRI prior to admission on 17th October 2013, but no comment on what was shown by the MRI. It is noted that the last slide in the presentation illustrated an MRI with a typical presentation of SIH on MRI, but not

an MRI of the patient whose case history was being considered. The management slide stated that the patient had received 4 epidural blood patch procedures without symptomatic relief. Further, management is noted as *“CT myelogram, targeted blood patch x 1 (short-lived relief of headache)/For repeat blood patch this week”*.

- 14.58 Commenting on the SIH cases, which Dr Watt had presented in 2016, Dr Craig reflected:

Into 2016, Dr Watt presented a series of these cases at our grand round. I wasn't there, and I'm told that nobody raised any concerns. So I don't know if these were a number of cases where they met the diagnostic criteria, but, clearly, of course, what we know now is that wasn't reflective of the patients that were actually getting it done, because Dr Peukert's audit tells us that. Out of, I think it was, 87 cases, he, was it, said 12, I think, he thought were appropriate, so there's an enormous disconnect there. Again, it's not a defence, but, from our perspective, we'd been presented with this new — not “new” but this — it had always been there but now better defined, diagnostically at least, set of criteria for this condition, given some assurance in a second meeting that the right cases were being done but now know actually that that was not the case.

- 14.59 Dr Hunt remembered that Dr Watt had been the leader of a session where some of these *“SIH cases were discussed”*. He recalled that it was all very conventional. He told the Inquiry Panel: *“There wasn't anything in it that made me sit up and think ‘that's a bit odd’”*.

- 14.60 The Inquiry noted that the third presentation in 2017 was primarily identified to the contents of Dr Watt's appraisal folder. The patient in question had Marfan's syndrome, who also gave evidence to the Inquiry Panel. No witness, including Dr Paul McMonagle, who was her original consultant, was able to reference the presentation by Dr Watt.

- 14.61 Dr Watt's case review structured template as contained within his appraisal folder stated:

21/05/2016 MRI brain and spine showing dramatic changes in keeping with intracranial hypotension

06/16 Lumbar blood patch x2

04/11/16 lumbar blood patch

14/02/17 lumbar blood patch

02/03/17 CT/T1 blood patch

Case discussed with Mr McConnell, ?compensatory changes over the years

preventing brain rising once leak repaired? Suggested admit for ICP monitoring before and after further patch – proved impossible to coordinate due to demands on the service and the multiple specialties involved.

Rapidly developing field. Sabbatical in US centre may prove invaluable.

The patient and her mother were very happy with the care provided and felt a partner in all our interactions.

The patient was referred to me for treatment by a colleague and, in the end, I took over her care at his request. I discussed her with a neurosurgical colleague and also presented her at our neurosciences meeting.

- 14.62 The Inquiry Panel noted with some surprise how few consultants could recall being present at any of the 3 presentations. The Inquiry, therefore, wrote to each consultant asking them to specifically look at their notes and see if this assisted their memory. This exercise yielded little further amplification from any of the consultants. It seems unlikely if there are normally 30-50 doctors (albeit including those from other neurosciences specialties) who normally attend the meeting, that so few neurologists attended the 3 presentations on SIH.
- 14.63 All of the consultant neurologists and relevant registrars responded to the Inquiry. The responses are set out in tabulated form as Appendix 1 at the conclusion of this chapter. In summary, 7 neurologists recalled attending the presentation given by Dr Hughes on behalf of Dr Watt in March 2014, 4 attended the presentation in February 2016 and 8 in March 2017.
- 14.64 It is also surprising that there seems to have been little curiosity or challenge to the huge number of procedures taking place which would have been readily apparent to anyone working in Ward 4E or alongside Dr Watt. The Inquiry Panel further noted that the third presentation in or about March 2017 occurred after Dr Watt had been partially restricted in December 2016 and after Dr Peukert had advised the Trust he had not approved the vast majority of blood patch procedures planned by Dr Watt. The Inquiry Panel accepts that the knowledge amongst consultants of the partial restriction was limited and some of those who would have known, such as Dr Craig, were not present at the Grand Round meeting. It still seems curious however that Dr Watt's presentations were not met with more surprise by his colleagues.
- 14.65 The Inquiry Panel did however note the evidence of Dr Collette Donaghy on 21st October 2020:

It was in and around the time of my awareness of the blood patch issue, I'm fairly sure, because I'm fairly sure I was aware of it at that stage when Dr Watt

presented a couple of cases. One of them I think was reasonable, and the other one I thought was lacking in information to support the diagnosis, which I raised with him and obviously, I think, others at the meeting -- I can't remember exactly which person, but obviously there were other consultants there and other people definitely, maybe the Registrars commented on the cases. But there was definitely one case towards the end of his presentation that I thought didn't have a secure diagnosis of SIH. It was very much in and around about that time of my awareness of the epidural blood patch increase.

- 14.66 The Inquiry Panel is aware of the importance to medical defence organisations and others of confidentiality in any disciplinary or other process. As stated above by March 2017 only very few neurologists were aware of the restriction (and not even the Clinical Lead had been briefed). Concerns about confidentiality are legitimate, but patient safety remains paramount. With the benefit of hindsight, it clearly would have been better if consultant neurologists had been better informed of the problems developing with Dr Watt's blood patch procedures and the existence of the partial restriction. This may have elicited a different response to the presentation in March 2017.

Dr Watt's Evidence on Blood Patch Procedures:

- 14.67 It is instructive to consider, at this juncture, the evidence obtained by the Inquiry from the Verita Report, which had been commissioned by the Trust as part of the MHPS investigation. Dr Seamus O'Reilly, Medical Director of the Northern Health & Social Care Trust was appointed by the Belfast Trust as case manager. The investigation team consisted of Kieran Seale, an investigator at Verita, Dr Michael Marrinan, Medical Director at the Royal Hospital for Neurodisability and Dr Chris Clough, Consultant Neurologist at Kings College Hospital. Various critical questions were put to Dr Watt when he was interviewed by the team on 28th May 2019. Their report was forwarded to Dr O'Reilly in July 2019.
- 14.68 The MHPS procedure was not completed because of Dr Watt's ill health. The answers that Dr Watt gave to the investigation team are the only response available to the Inquiry to the questions that arose because of the dramatic increase in blood patch procedures. It may well have been appropriate to ask Dr Watt to give his feedback on the Verita Report, but his inability to do so should not have prevented the completion of the MHPS process. There is a clear danger that those implementing the current MHPS process have become overly fearful of legal challenge. This potentially undermines patient safety and public confidence.

14.69 The Verita Panel specifically asked Dr Watt about his practice of blood patch procedures and the increase that had occurred. Dr Watt described a patient where the history sounded typical of intracranial hypotension. The imaging evidence was negative and Dr Watt, from his own research, concluded that one could still suffer from intracranial hypotension, even with normal imaging. He thought it was reasonable to proceed and the intervention was, in Dr Watt's evidence to the Verita Inquiry, extremely successful. He commented on the development of his interest when asked whether he had discussed the procedure with any of his colleagues. Dr Watt stated:

No. Blood patch, normal bog-standard lumbar patch, by luck - or by misfortune in hindsight, perhaps, because I mightn't have gone down this path if it hadn't worked – worked like a charm, so this guy who had been incapacitated by headache for four years was fine, and working away full time again, where he hadn't been. That then led me to look at some of the other patients that had been attending me for a long time, and who I still wasn't particularly content that I'd got the right diagnosis and looking back at the initial presentation with intracranial hypotension in mind, looking at their original story with this as an idea and finding unfortunately quite a few of them would have fitted for intracranial hypotension, and blood patching those patients.

14.70 Dr Watt informed the Verita Panel that until he had treated the patient described above: *"I would never have patched anybody with normal imaging up until I met that chap"*. When asked by Dr Clough from the Verita Panel whether he considered the practice to be *"ahead of the game"*, Dr Watt stated:

It was certainly ahead of the game here. Was it ahead of the game on a more international scale? There were centres who were writing about this and producing various educational videos and things around the world that were doing something similar, so I suppose any time I did something that was further than I'd done before I would have read it up, so somebody had already written about this somewhere, it was based on having looked at it and thought, okay, that's been described.

14.71 Dr Watt was specifically challenged by Dr Clough that his practice was *"out of kilter"*. He replied:

Yes, it is, but it did seem right to me, I think it would have been helpful if we'd managed to audit it - I did try and get several of the juniors to audit it, but I didn't succeed in that, but my overall feeling had been, I suppose probably through rose-tinted glasses, that it was helping in about half the patients that I'd performed it on.

I was trying to refine my diagnosis, I suppose, by doing it and then trying to work out from various presenting symptoms who was most likely to benefit from this, and even before all this happened, I was starting to pull back a bit.

14.72 When asked about the process put in place by Dr Peukert, Dr Watt indicated that Dr Peukert was basing his view on the published guidelines:

He [Dr Peukert] was in an awkward position, so he could not – the published guidelines at that stage from the International Society for the Diagnosis of Intracranial Hypotension, you had to have abnormal imaging.

14.73 Asked as to whether it was appropriate to go beyond published guidelines, Dr Watt responded:

I thought that what I was doing was based on the evidence that was in the literature at the time.

14.74 Dr Watt also confirmed that he took the view that it was reasonable to use a blood patch procedure as a diagnostic test.¹³ The draft Verita report concluded that the adoption of “*an extreme practice in blood patching*” without the benefit of any academic rigour together with a formal or informal consultation with colleagues, supported the conclusion that Dr Watt’s practice was unsafe.¹⁴

14.75 Based on Dr Watt’s evidence to the Verita investigation team, the following statements can reasonably be made:

- (i) Dr Watt commenced blood patch procedures on a much more extensive basis when he successfully carried out the procedure on a patient who had negative imaging results, but a history which was consistent with some of the symptoms of SIH.
- (ii) Prior to his involvement with that particular patient, he would not have “*patched anybody with normal imaging*”.
- (iii) He accepted that his practice was “*out of kilter*” with colleagues, but he felt there were other centres internationally who were writing about the same thing and doing something similar.
- (iv) Dr Watt felt it was appropriate to go beyond published guidelines based on his assessment of the literature at that time.
- (v) Dr Watt believed it was reasonable to use blood patch procedures as a diagnostic test.

¹³ See paragraph 5.70 of the Verita report.

¹⁴ See paragraph 7.12 of the Verita report.

- 14.76 As noted previously the Inquiry Panel is not in a position to determine the efficacy of blood patch procedures in cases of SIH but does note that Dr Watt pursued his revised course of action in operating outside the published guidelines without explicitly informing his colleagues or auditing the approach that he was taking. This would undoubtedly have made it more difficult for the Trust to manage. It is accepted that Dr Watt did present to the Neurosciences Grand Round, on three separate occasions, cases, which involved both the diagnosis of SIH and treatment by way of a blood patch procedure. What is not at all clear, however, is that he informed his colleagues of his approach to using a blood patch procedure diagnostically or in carrying out the procedure in the absence of imaging evidence.
- 14.77 Even allowing for a degree of confusion about imaging evidence, and the lack of any clinical audit, it is still remarkable that the astonishing increase in blood patch procedures following a diagnosis of SIH was not properly questioned by the Trust or indeed by Dr Watt's colleagues. As detailed later in this chapter the focus at that time was much more on the issue of capacity and the impact that the procedures were having on other neurology services.

The Evolution and Development of Dr Watt's Blood Patching Practice: 2011-2016:

- 14.78 The Inquiry Panel sought to understand how Dr Watt's blood patching practice had evolved. The earliest email communication obtained by the Inquiry, which related to a blood patch procedure was from Dr Watt's secretary, dated 11th February 2011. She stated:
- Just to let you know that Dr Watt has told a patient to come on Monday morning at 10am for a blood patch. I think his name is [redacted] but will need to get his details from Dr Watt to record him on PAS.
- Other emails at that time refer to patients coming to the Neurology ward for a blood patch procedure.
- 14.79 By 2014, some of the emails refer to patients phoning Dr Watt's secretary to arrange further blood patch procedures. At that juncture, Dr Watt was discussing the procedure with Dr Graham Smyth, Consultant Neuroradiologist, and Mr Philip Frizzell, the then Superintendent Radiographer and subsequently the Service Improvement Manager for Radiology,¹⁵ regarding patients undergoing blood patch procedures.

¹⁵ Between December 2015 and September 2016, Mr Frizzell was the Service Improvement Manager: "This was a new role created to include an examination of the funding and cost issues, given the expanding Imaging Service, particularly in the area of Interventional Radiology." Between 2010 and 2016, Mr Frizzell's role was to co-ordinate all outpatient examinations for Interventional Neuroradiology.

14.80 The Inquiry notes that in March 2014, Dr Paul Burns, Consultant Neuroradiologist, emailed Dr Watt questioning the utility of repeat blood patch procedures. In an email of 4th March 2014, Dr Watt had stated:

The T1/2 targeted blood patch which Graham [Smyth] and I did on that lady last Friday worked for about 90 minutes.

As Graham is off would you fancy giving it another go sometime this week.

Dr Burns replied on 5th March 2014 as follows:

Pity. Is there much of an expectation that a repeat procedure would be of benefit though?

14.81 The emails disclosed to the Inquiry also suggested that, in or about March 2014, some of the side effects of undergoing an epidural blood patch were apparent. On 21st March 2014, Mr Philip Weir emailed his neurosurgery consultant colleagues and gave an overview of various patients for the purposes of handover. In relation to one patient, Mr Weir noted:

Michael Watt did a blind blood patch 8 days ago, which is giving her sciatica, but she is otherwise intact ... There is nothing to do, she can't have more blood patch, given her sciatica ... Michael Watt should probably see her before she goes in case he wants to try targeted blood patches to the C7 root sleeves.

14.82 On 27th October 2014, Dr Catherine Donaldson, then Registrar to Dr Watt, wrote to, a GP in Templepatrick in relation to a patient who had had several blood patch procedures, noting:

She has however developed severe back and left hip pain. She is taking a lot of analgesia because of this. She feels this only occurred following her third blood patch on 7th October 2014 ... She is unable to walk short distances due to the pain ... Dr Watt felt that her pain was likely sciatic pain secondary to the blood patch.

14.83 The frequency of blood patch procedures appeared to be increasing as time went on. On 7th January 2015, Mr Philip Frizzell, Interventional Superintendent Radiographer at the Royal Victoria Hospital, emailed Dr Smyth and Dr Watt as follows:

Can we plan the patients for the next three Thursdays when you are both available please.

14.84 On 2nd February 2015, consultants Dr Seamus Kearney, Dr John McConville and Dr Mark McCarron discussed by email the efficacy of the procedure. This was of interest to the Inquiry because the consistent theme from many neurologists was

that Dr Watt had a keen interest in both SIH and blood patch procedures and was the only neurologist who had developed an expertise in them. Dr McDonnell, in his evidence, for instance, did not consider there was a senior headache specialist who could have challenged Dr Watt or commented authoritatively on the dramatic increase in procedures. The Inquiry noted, however, that in February 2015 three consultants were discussing the procedure with a degree of caution. No reference was made to any particular special interest on the part of Dr Watt or the need to involve him in their deliberations.

- 14.85 Initially, Dr McCarron posited that cases which had orthostatic tremor had been “*cured by blood patching*”. Dr McConville stated on 2nd February 2015:

We need to devise basic inclusion criteria: I think secure evidence of a low-pressure state (MRI changes or documented low CSF pressure directly measured, ideally with suggestive clinical features) plus a cognitive/movement/brainstem disorder (or is that too permissive?)?

Dr Kearney responded on 3rd February 2015:

Absolutely. Not every symptom that has postural variability is due to intracranial hypotension, even if there is an apparent improvement with epidural blood path. Need typical MRI changes or documented opening pressure to ensure credibility.

- 14.86 On 2nd February 2015, a lady emailed the Complaints Department on behalf of patient INI 436 and wished to make a formal complaint about his treatment and the cancellation of his appointment in January. This email was not included within the original complaint documentation disclosed to the Inquiry by the Trust. The email stated:

... [INI 436] was referred to Neurology at the Royal Victoria Hospital where he was diagnosed as having orthostatic tremor due to spontaneous intracranial hypotension. His consultant at the Royal Victoria Hospital, Dr Michael Watt, tried blood patches on 4 occasions (1 private and 4 through the NHS) to try and rectify the matter but to no avail ...

- 14.87 The focus of the response to the complaint was on explaining the alleged missed MRI appointment in January. There was no query, however, as to Dr Watt administering blood patch procedures on 4, or possibly 5, occasions and no investigation into such a statement.

- 14.88 The first time that Ms Clare Lundy, the Assistant Service Manager, seemed to be aware of patients attending Ward 4E to undergo blood patch procedures was when

she was contacted by Sister Vanessa Boyd, the Admissions and Discharge Co-ordinator, advising that the volume and frequency of such procedures had increased and requested if the procedures could be performed elsewhere.

- 14.89 Sister Vanessa Boyd made strenuous efforts to try and address the influx of patients seeking a blood patch procedure from Dr Watt. She gave very specific details of some patients, including one who had attended 4E at least 3 times but for whom nothing was recorded; a patient who attended after their daughter asked Dr Watt to perform the procedure; a patient who had attended on “at least” 5 occasions for the procedure and was initially a private patient; another patient who had to be admitted because she became so unwell after the procedure; and the fact that on one afternoon, 3 procedures were performed (on the ward).
- 14.90 These matters were set out in an email of 9th March 2015 from Sister Vanessa Boyd to Ms Clare Lundy, which stated:

I am just coming back to you with as much info as I can re Blood patches being done on 4E. The volume and frequency of these procedures seems to be increasing and I was wondering if there was any chance of them being performed elsewhere as 4E is a very busy combined ward that we have worked hard to move day cases from in the past.

Patients that I am aware of.

[INI 483]

Referred from Dr Forbes in Craigavon.

This man has attended 4E at least 3 times but nothing recorded.

I spoke to [Dr Watt’s secretary] re this – She is equally concerned that these have not been captured and is trying to get dates for me

[INI 473] – she has attended on at least 5 occasions for blood patch. These are:

30.10.14

10.11.14

4.12.14

19.2.15

9.3.15

[INI 481]

Not sure where she was referred from.

She has attended on at least 3 occasions

21.12.14 - Admitted till 24.12.14

7.2.15 – Came as day case but required admission

6.3.15 – Came as a day case but only because Ursula did a favour for me when I knew that she was booked

[INI 474]

Not sure of means of referral

Attended 16.2.15

Attended 20.2.15 but had to be admitted because was so unwell

I am sure there are more

[Dr Watt's secretary] and I have managed to construct this list but I know there will be others

I know that there was 1 afternoon when 3 were performed. V

- 14.91 The email from Sister Vanessa Boyd is significant because it raises a series of issues around blood patch procedures: (i) the capturing of procedures on PAS i.e., making sure the Trust has a record of the patient undergoing the procedure; (ii) the transfer of private patients; (iii) the frequency of procedures; and (iv) the fact that some patients were becoming unwell. One can, therefore, infer that the Trust management were aware of issues arising at that juncture. Further, based on the evidence of neurologists at the Inquiry, all who offered a view would have been alarmed both at the sheer volume of patients requiring the procedure in a short space of time and the number of repeat procedures patients were undergoing.
- 14.92 Ms Lundy responded to Sister Vanessa Boyd by email dated 9th March 2015:
- These patients should not be attending Ward 4E for this procedure without prior discussion and arrangement. Who authorised this?
- 14.93 Ms Lundy, on the same day, emailed Dr Watt, copying in Dr Craig and Mr Gerry Atkinson, the Service Manager, and stated:
- I have noticed that there has been a significant increase in activity in the Clinical Room in Ward 4E. Apparently there are quite a few patients who are attending Ward 4E for blood patches.
- Can we please meet to discuss this? Have you attempted to have this procedure carried out in the Programme Treatment Unit, as this is a more suitable venue?
- 14.94 It is noted that at the same time as Ms Lundy was querying the attendance at Ward 4E for blood patch procedures, the final version of a response to a complaint on behalf of INI 284 was completed. That response highlighted the fact that Dr Seamus Kearney was of the view that, in a patient diagnosed by Dr Watt with SIH, there were no objective abnormal neurological findings and no evidence of intracranial hypotension. It was noted that Dr Watt had performed two blood patch procedures without effect.

14.95 The complaint response, if it had been combined with a growing number of queries about both the volume of blood patch procedures and the inappropriate use of Ward 4E, could have been utilised as a means of asking much more specific questions of Dr Watt. This opportunity in early 2015 was, however, not taken.

14.96 Dr Watt's secretary in her evidence to the Inquiry Panel on 2nd September 2019, explained her predicament in booking procedures:

Mr Lockhart QC: Did they go up a little bit? Or ... did they grow hugely?

Dr Watt's secretary: They sort of started – on a weekly basis, you were getting phone calls from the ward.

Mr Lockhart QC: That was ward 4E?

Dr Watt's secretary: Yes. To say that a patient had arrived. So, then, they started trying to organise them. Most of the time it was just – a lot of the time they were landing in 4E.

Mr Lockhart QC: What was your role in that?

Dr Watt's secretary: If I knew about a patient, I got them pre-admitted on the patient centre; you know, the administration. Organised the chart and had it up on the ward for the patient to view at the appointment.

Mr Lockhart QC: And were there any difficulties for you in trying to arrange it at all? Did you find this difficult? Was there pressure put on you?

Dr Watt's secretary: When the ones that just turned up to the ward, I like a chart to be there so that - . So, there was running about trying to get stuff up to the ward for patients that I didn't know nothing about.

Mr Lockhart QC: And how did that occur? Do you know how that happened?

Dr Watt's secretary: He could've just saw patients and just says, "Come for a blood patch". To me, that's just the way they started.

14.97 The question of the efficacy of the procedure was also drawn to Dr Watt's attention in April 2015. The interaction between Dr Watt and his secretary regarding a patient who had undergone numerous blood patch procedures is instructive:

From: [Dr Watt's secretary]

To: Michael Watt

1st April 2015 @ 09:18

This gentleman's partner rang again to say that her problems are back again. She is very bad this morning again with crackling in her head. Can you advise please.

From: [Dr Watt's secretary]
To: Michael Watt
2nd April @ 09:39

This gentleman has rang again.

From: Michael Watt
To: [Dr Watt's secretary]
2nd April 2015 @ 10:17

Why ringing us?

From: [Dr Watt's secretary]
To: Michael Watt
2nd April 2015 @ 10:26

Because you have done four blood patches on her already and they are looking to come down and speak to you.

- 14.98 The extent to which the blood patch procedure was being carried out was, thereafter, repeatedly highlighted in the emails that have been disclosed to the Inquiry. On 29th April 2015, Sister Vanessa Boyd emailed Ms Lundy and stated:

This is now 4 blood patches that Dr Watt has booked for Thursday! ... I think that someone needs to sort this. These should not be coming to the ward. Not sure where else they can go but this workload is just increasing every week.

- 14.99 At the same time as pressure was building up within Ward 4E, further evidence also emerged of patients who had experienced complications following a blood patch procedure. In a letter to a patient's GP dated 23rd April 2015, Dr Rachael Kee, Neurology Registrar, noted:

... She is known to Dr Watt with spontaneous intracranial hypotension and underwent an epidural glue and blood patch on Thursday prior to this admission. Following this procedure [the patient] reports that she felt ok and went home without a significant headache. She then woke up on Friday morning with bilateral throbbing sensation around her neck and a global headache. She states this was exacerbated on any movement of her neck, there was associated nausea and vomiting. She also had photophobia.

On admission there was evidence of meningism. Tone, power and reflexes were all normal. It was felt that this was an aseptic meningitis secondary to the Tisseel glue. [the patient] was managed with fluids, bed rest and simple analgesia. She underwent an MRI brain and spine on 6th April which showed mild inferior displacement of third ventricle but no other signs that could be attributable to intracranial hypotension. There is a T2 hypointense posterior thoracic epidural

collection with no change to size or evidence of cord compression. White cell count was 4.9, CRP was 5.6. She remained afebrile. Over the following few days [the patient's] symptoms started to improve significantly. This headache was significantly improved by 10th April. There was no postural element. She was mobilising around the ward. The nausea and vomiting had settled. She described a minimal throbbing occipital headache now occurring on a daily basis without a postural element and it is likely that this is an element of chronic daily headache and we suggested trying Amitriptyline for this. The patient was clinically well and keen for home and was therefore discharged on 10th April 2015 ...

- 14.100 In an email of 29th April 2015, Ms Lundy asked to discuss the matter at the Clinical Leads meeting on 30th April. The Inquiry has not seen any evidence that that intended meeting took place. The minutes of the fortnightly Clinical Leads meetings contain no reference to blood patch procedures until August 2015. The Inquiry Panel is of the view that the lack of any evidence points to the probability that the issue was not, in fact, discussed at a Clinical Leads meeting until August 2015.
- 14.101 The pressure on Dr Watt's secretary to arrange blood patch procedures, and the difficulties in keeping track of the number that were occurring, is highlighted by various emails in April 2015. One example is on 29th April, when Dr Watt's secretary emailed Sister Boyd to assist her in identifying the number of blood patch procedures:

I have went through my emails from the start of January and these are the ones I have emailed you about and a few that weren't on email that I have remembered.

[INI 473] x 6

[INI 474] x ?3

[INI 475]

[INI 476]

[INI 477]

[INI 478]

[INI 479]

[INI 480]

[INI 481] x 3

This is including the patients who are attending tomorrow. I am not sure if this is them all or not. If I remember any more I will let you know.

Sorry about the meltdown today.

14.102 Another example was on 30th April, where Dr Watt's secretary emailed Sister Boyd as follows:

Two more for the blood patch list.

[INI 482] x 2

[INI 464] x ?3

I am not sure if [INI 436] had one on 09/04/15. There is mention in his letter from January about CT myelogram along with an image guided epidural blood patch but I'm not sure if the blood patch was carried out as well as the CT myelogram on 09/04/15.

14.103 Sister Boyd forwarded the email to Ms Lundy for the issue to be discussed at the Clinical Leads meeting due to take place on 30th April.

14.104 In a written statement of 9th September 2021, Ms Lundy stated:

I have been asked whether the subject of EBPs was discussed at a Neurosciences Service Clinical Leads Meeting before the meeting on 13 August 2015, when it was noted that the procedures were no longer being carried out on the wards. Unfortunately, I cannot provide a definitive answer to this question. I cannot, at this remove remember the discussions that occurred. I cannot see the subject recorded in the available records of the meetings. However, I also cannot say that it was not discussed. The issue in 2015 would not have had the significance that mention of the term EBP now has.

14.105 Earlier in her statement, Ms Lundy explained by way of context:

It is important that I make clear that the issue in 2015 was the location in which blood patches were being carried out, not whether they were an appropriate medical procedure.

14.106 The Inquiry has seen no evidence that the Clinical Leads meeting did take place on 30th April. Further, the minutes of the fortnightly Clinical Leads meetings contain no reference to blood patch procedures until the August 2015 meeting. The Inquiry Panel is of the view that the lack of any evidence points to the probability that the issue was not, in fact, discussed at a Clinical Leads meeting until August 2015.

14.107 On 11th May 2015, Ms Lundy made a further attempt to prevent Dr Watt from doing blood patch procedures in Ward 4E. In what appears to have been a tense email exchange, she asked Dr Watt to immediately cease organising blood patch procedures using the clinical room in Ward 4E because it was an acute setting and was not suitable for the outpatient procedure. Dr Watt responded on the same day and replied: "Are you going to arrange for them to be done elsewhere or shall I just stop

doing them completely?" In response, Ms Lundy reiterated that Ward 4E was not the correct setting. The email was copied to the Clinical Director, Dr Craig, and the Service Manager, Mr Atkinson.

14.108 On 12th May 2015, Dr Watt repeated his earlier question from the previous day. He stated: *"You do realise that they will all now have to be admitted and may remain inpatients for months until they are sorted"*. Ms Lundy raised a query as to what had happened previously. Dr Watt responded:

No, it's not new, we have always done a few. What has changed is the increase in the numbers being diagnosed in the past year due to an increased awareness among the neurologists and neuroradiologists and because I have always done a few blood patches they are being referred to me. There is an element of catch up at the moment – some of the patients I'm treating at the moment have had their problems for several years so the numbers should drop off.

14.109 Ms Lundy reiterated that the ward was not suitable for the procedure and that she would discuss the matter with Sister Vanessa Boyd. In response, Dr Watt stated:

I entirely agree ... I do, however, think that the best option is for me to continue doing them after my ward rounds on Monday mornings and Thursday afternoons until new arrangements in place.

14.110 Despite the focused nature of the interaction between Ms Lundy and Dr Watt, the problem was not resolved. By July 2015, blood patch procedures continued to take place in Ward 4E but were also being facilitated by the DSU and Ward 2F, in addition to those image guided blood patch procedures arranged through neuroradiology.

14.111 Ward 2F was set up in 2015 as a pilot project with the aim of reducing hospital admissions. Nurse Paula Sterling, who had been approached to set up the project described it to the Inquiry Panel as follows:

So, the theory was to go round and look at all the patients, where there was a decision to admit on — the medical patients — and look at the ones that were there in the morning time to see: could we take them off the take to get them reviewed by a consultant and out the door quicker than being put upstairs to a bed, and then being seen by the consultant the next day?

14.112 It was agreed by Sister Sterling that the unit was not designed for blood patch procedure patients. Professor Mascie-Taylor asked Sister Sterling about this:

Professor Mascie-Taylor: But we're told that — and if we're wrong, do tell us, please — but we're told that you also looked after the blood patch patients.

Sister Sterling: Well, I wouldn't really have seen them. I facilitated them, as in

I had side rooms where —. When we got patients over, our doctors would've taken them to the side room and reviewed them and then let them out. And I had space in side rooms ...

They used to be done up in 4F. 4F had been closed for a period of time due to — I think it was pseudomonas.

Professor Mascie-Taylor: It was, yes.

Sister Sterling: And Dr Watt clearly did these in the clinical room or something up there, but all I — Vanessa came down and said can I spare a room to facilitate Dr Watt doing procedures.

Professor Mascie-Taylor: So, in terms of consent or record-keeping or any of that?

Sister Sterling: All I have is name and hospital number to be put on the PAS¹⁶ system.

Professor Mascie-Taylor: Right. So, you'd put it on PAS.

Sister Sterling: The ones that I knew about, yes.

Professor Mascie-Taylor: Right. That begs the question: well, what about the ones you didn't know about?

Sister Sterling: I didn't hear until —. I think it was one of my days off when I heard he had come through with a patient, but it wasn't documented. So, he would be showing up with patients. Now, any time I caught him showing up with a patient, I would have stopped him. Because he would just come in and say, "Have you got a room free?", and then I would get the details off him with regards to the patient.

Professor Mascie-Taylor: Right. So, once he knew there were rooms free there —

Sister Sterling: He'd come down.

Professor Mascie-Taylor: — he'd come down with the patient and say, "Can I just use the room to do this?"

Sister Sterling: Uh-huh.

Professor Mascie-Taylor: Right. And that patient wouldn't be booked?

Sister Sterling: No, but if I got the patient's name and hospital number, it would've been booked.

Professor Mascie-Taylor: Well, you'd book it almost in retrospect when you were booking.

¹⁶ Patient Admission System.

Sister Sterling: Yes.

Professor Mascie-Taylor: But if you didn't do that, it wouldn't.

Sister Sterling: It wouldn't be picked up.

Professor Mascie-Taylor: Right. Now, was Dr Watt the only doctor that did this or was this normal?

Sister Sterling: No. He was the only one that did it.

14.113 On 20th July 2015, Sister Boyd emailed Ms Lundy in the following terms:

As a matter of urgency something needs to be put in place to manage the volume of blood patch referrals that are being given to me to arrange for Dr Watt.

Today I have had 5.

Initially there were 2 which I have sorted through DSU for this Thursday – One of these is going to require glue. He has just texted me another one that he has presumably seen in Hillsborough Clinic this afternoon.

[Dr Watt's secretary] has just emailed me another 2 who require dates.

The volume of these patients is increasing each week and has now reached a stage where I feel he needs a clinic set up on a given day every fortnight to be able to deal with them.

Whilst I appreciate that these patients are day case admissions, I feel that it is unreasonable to be given so little notice of the patients and then be expected to sort them all out.

It is almost a job in itself.

A meeting with Dr Watt needs to be arranged to work out how best to plan these in the future.

[Dr Watt's secretary] is equally frustrated by these referrals.

14.114 On the same day, Sister Boyd emailed Dr Watt and suggested a meeting to organise the best way of managing blood patch procedures in the longer term. Responding to the email, Ms Lundy emailed Dr Watt, Sister Boyd, Dr Craig and Mr Atkinson asking pertinent and searching questions. She deserves to be commended for the clarity of her observations:

As ward 4E and ward 4F are now augmented care areas. It is very inappropriate for these procedures to be completed in the department. It needs to stop.

- These need to go through PTU and booked appropriately.

- Are these patients on a waiting list?? If not, they should be.
- Can you advise if the activity is recorded on PAS? If not, it should be.
- Is any of this work 'private'?
- How are the referrals made to Dr Watt and how are they recorded?
- What protocols are in place for these patients?

We require a formal meeting before any more patients are provided with appointments.

I did have a conversation with Martin Harley, and he forwarded a protocol to PTU, but a formal agreement is required.

14.115 Sister Boyd replied by email of 21st July 2015 to those questions explaining the difficulties encountered by nursing staff:

Just so you have this in Email

1 – [Dr Watt's secretary] and I do try to get beds in PTU/DSU or 2F – Often we have only a few hours notice that they have been booked to come to

4E – We do our best to move them out of the ward – However, more often than not the patients are brought up to 4E so that another member of medical staff can assist – regardless of beds having been booked

2 – To my knowledge there is no waiting list for these patients – It would appear that referrals come to Dr Watt from other consultants and GPS – Often he will get referrals over the weekend and then tell them to come on Monday AM to the ward – [Dr Watt's secretary] and I know nothing about it till they come. We are usually told about Thursday admissions on Monday or Tuesday

3 – We are trying to put all activity on to PAS and have done this retrospectively for all those that we are aware of – Database attached

4 – Possibly some of these are private patients – I can think of at least 3 that have come through the UIC

5 – See point 2

6 – There is no protocol in place for these patients to my knowledge although Martin Harley did say that he was on this weekend and would try to complete application form for same

Additional concerns are that Neuroradiology are now also being asked to regularly provide glue and levels – This has a costing implication. (Might ask Phillip Frizzell to attend meeting too as I know he has concerns)

Thanks a lot

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14.116 The number of blood patch procedures did not appear to have abated. A meeting was eventually arranged on Friday 24th July 2015 in the Neuro-Admin Office. Prior to that meeting, on 21st July 2015 Ms Lundy had emailed the Clinical Director, Dr Craig, in the following terms:

I am really concerned about the practice of blood patches being performed in the clinical room in ward 4E.

I don't understand, why has this service been started without discussion or negotiation?

I don't know how referrals are received, who from and how the waiting list is managed?

Also, why is there been [sic] such a need for this procedure? This is new.

I am aware that the radiology dept are also concerned regarding the use of 'glue'. As I don't fully understand the process of using 'glue' I am unable to comment regarding this. However, there is a significant cost implication. Should radiology being [sic] involved in this process?

From an environmental perspective, the sheer congestion that two additional outpatient clinics cause, every week, in the clinical area, is alarming ...

14.117 Reference to the Radiology Department referred to the input of Mr Philip Frizzell, then Superintendent Radiographer. In a written statement to the Inquiry of 5th July 2021, Mr Frizzell referred to the cost implications and that he had concerns from the start of the growth in blood patch procedures and:

... about the unfunded nature of the developing service ... I discussed the issue informally (which I define as a "corridor conversation" with another, as opposed to a discussion with colleagues in a meeting) with the Consultant Radiologists involved, and with Dr Watt and Sister Boyd ... "

14.118 Ms Lundy followed the matter up with a frank email to the Service Manager, Mr Atkinson, on 21st July 2015:

FYI

Dr Watt just doing what he likes in the ward. We are all busting our asses to keep the environment clean, tidy working with all MDT staff for compliance and then he comes in his flaunting non-compliance! Not good!! Frustrating.

14.119 Ms Lundy spoke to, and emailed, Mr Frank Young¹⁷, Co-Director of Unscheduled & Acute Care, raising her concerns about the use of Ward 4E and forwarded on

¹⁷ Co-Director of Unscheduled & Acute Care.

her email to Dr Craig at [116] above. Mr Young agreed to raise this directly with Dr Craig, in his meeting with him on 23rd July. On the same day, Ms Lundy also emailed her colleagues Sister Boyd, Dr Craig, Mr Atkinson and Jill Wilson, Ward Sister at 4E, stating:

I have broken the news to Dr Watt that the neurosciences dept. is no longer able to facilitate blood patches. I have advised that Vanessa and I will explore the possibility of two beds in day of surgery [sic] every Thursday, if possible.

I still think we should pursue the meeting on Friday.

14.120 The meeting on 24th July 2015 was to be attended by Dr Watt, Dr Craig, Sister Vanessa Boyd, Dr Watt's secretary and Ms Lundy. In the event, only Dr Watt, his secretary and Sister Vanessa Boyd attended, although Ms Lundy recalled coming late to the meeting. Asked about this, Sister Vanessa Boyd stated:

Mr Lockhart QC: ... there was a mention of a Friday afternoon meeting that you tried to talk about blood patches and the meeting referred to emails of 21st of July. Who was due to attend that meeting? Do you remember?

Ms Boyd: I think that it was John [Craig], Clare [Lundy], myself, Michael [Watt] and [Dr Watt's secretary], but, at the end of it all, there was only myself, [Dr Watt's secretary] and Dr Watt turned up.

Sister Vanessa Boyd was content at that time because the plan was for the procedures to be carried out elsewhere.

14.121 Sister Vanessa Boyd contacted Ursula Hamilton, Ward Manager for the Day of Surgery Unit, that afternoon seeking the use of its facilities to accommodate two blood patch procedures a week. DSU took the view that it was an inappropriate environment and to facilitate the procedures would compromise bed capacity for surgical patients. Having spoken to Sister Betty Boyd, who was in charge of PTU, and advised they did not have sufficient staff to assist, Sister Vanessa Boyd advised Ms Lundy, Dr Craig, Dr Watt and Mr Atkinson on 27th July that she had exhausted all options, including the PTU and Ward 2F. On 28th July 2015, Sister Vanessa Boyd emailed Dr Watt stating:

All permeations equally repellent when addressing the BP issue. [...] Not sure how to sort – all roads seem to lead to 4E but I know this will potentially lead to NMC referral for me.

14.122 It is clear from the evidence of both Dr Craig and Ms Lundy that they initially believed that the problem of blood patch procedures being carried out on Ward 4E had been solved and that, therefore, the meeting on 24th July had become

unnecessary. What is apparent, however, is that the interactions did not trigger broader questions as to why there were so many procedures in the first place. Nor did they address or consider the other issues, in addition to location, as raised by Sister Boyd in her initial email of 20th July 2015, (see [114] above). These included the booking system and the need for a waiting list; the transfer of private patients to the NHS; the recording of the blood patch procedures; and the use of protocols. All of the aforementioned would subsequently transpire to have been concerning.

- 14.123 An administrator subsequently provided an up-to-date list of all blood patch procedures on 30th July to Sister Vanessa Boyd. This revealed 45 such procedures had taken place between October 2014 and July 2015, but subsequent email correspondence highlighted a number of missing patients in that database.
- 14.124 Almost immediately a blood patch procedure caused further serious problems on Ward 4E. Nurse Lynn Arnott emailed Mr Atkinson, Dr Craig, Ms Lundy and Sister Vanessa Boyd on 5th August advising that she was unable to provide treatment to a patient for an hour and a half because a patient who had undergone a blood patch procedure was occupying the treatment room.
- 14.125 In reply, Sister Vanessa Boyd provided a detailed description of the problem, copying in Mr Atkinson, Dr Craig, Ms Lundy and Mr Steve Cooke:

Thanks for this Lynn.

This seems to be an ongoing problem and I am unsure how to sort out the issue of blood patches on 4E. It would appear that the requirement for this procedure has escalated significantly in recent months – With at least 4 being arranged on most weeks.

I often have no knowledge of the patients until 1 or 2 days before the procedure and trying to find a suitable venue at such short notice, is very difficult although [Dr Watt's secretary] and I do our best. For example – On Monday, I was told that 2 were coming on Tuesday.

PTU has no capacity to absorb the additional workload (They have 50% staff vacancies). Even when the PTU capacity is increased, Betty [Sister Boyd] is unsure how much additional Neurology she will be able to accommodate. Dr Harley has been asked to fill in a request for PTU to take this over in the long term, but I am unsure if this has been done.

DSU had originally agreed to house 2 patients each Thursday afternoon, but after a quite traumatic procedure last Monday it was felt that this was an unsuitable venue and the Sister there will take no more bookings for same.

2F can occasionally help – But their first priority is to the A+E overspill – So it is impossible to pre book these beds.

We have been told that 4E is NOT to be used for blood patches. However – Patients continue to be told to come here. It would appear that a regular clinic is required somewhere to accommodate the increased demand for this procedure.

Any ideas on how to sort this out would be greatly appreciated – Discussion at Clinical leads is a great idea.

14.126 Dr Craig replied as follows, adding the Clinical Lead, Dr Gavin McDonnell to the email chain:

I thought we had decided that this procedure was not to be done on ward 4E and certainly not for outpatients, especially on such an ad hoc basis.

Whoever is in charge should therefore refuse to let the test be done on ward 4E when requests come in. The procedure could not be defined as being urgent and therefore apart from inpatients all procedures should be planned.

It is up to the medical staff to find an appropriate venue consulting with colleagues in management.

14.127 The matter appears not to have progressed further for some time, but by October 2015, Dr Martin Harley had completed a request for blood patch procedures to be undertaken in the PTU. Additional capacity could not be secured at that time, so arrangements were made to replace two of the six slots for neurology lumbar punctures on a Thursday afternoon with blood patch procedures. As the neurology day case registrar at that time, Dr Harley confirmed the two slots per week from 3rd December onwards by email to Sister Vanessa Boyd, Dr Watt, Ms Lundy, and Dr Craig. On 16th October 2015, Dr Craig seemed to be content with the arrangement and congratulated everybody on their efforts. In truth, however, what was perceived to be the agreed arrangement was far removed from what occurred in practice in terms of the number of blood patch procedures being undertaken on a weekly basis by Dr Watt and the continued chaos around the booking in of patients for the procedure.

14.128 On 29th October 2015, Dr John McKinley wrote to his consultant colleagues in Neurology regarding the displacement of day case slots with blood patch procedures. This email is important because it reflects a view regarding the frequency of blood patch procedures, which was unchallenged and not appropriately questioned by consultant colleagues. Dr McKinley stated:

From my perspective, I always think of blood patching as being an infrequently performed (and required) procedure within Neurology. If we are now developing a new service to electively perform this procedure at the expense of routine and urgent outpatient neurology investigations, then surely this should have warranted:

- i. Discussion at a Consultant meeting prior to the implementation of the new service.
- ii. Demonstration of need (based on the provision of data) given that our entire capacity for LP is 6 slots on a Thursday afternoon (to service the patients of all Belfast Trust Consultants and those referred from DGH Consultants). My understanding is that the Wednesday PM slots are largely for IT baclofen pump refills.

This new model effectively reduces capacity for day case LPs and other procedures by 33% and I think a waiting time of 3-4 months for investigation is getting a bit long (given that recently the shortest waiting time has been circa 8 weeks).

Should we not look into this in a bit more detail before implementation?

14.129 He followed that up with a private email to Dr McDonnell that evening, stating:

Gavin did you know that 2 of the 6 PTU day case slots have been handed over to MW [Michael Watt] for blood patches?

When grading letters, I have not seen a massive influx of apparent low-pressure headaches from GPs so where are they all coming from?

Dr McDonnell responded to Dr McKinley as follows:

John, it's news to me. Could have been mentioned at a leads meeting but I am not at these at present. Seems incredibly excessive – must be Michael Watt's private patients who need a catchy diagnosis rather than a functional one. The wait for diagnostic LP would be unacceptably long.

Will send a questioning email tomorrow as to why we need 90-100 such outpatient slots on an annual basis.

14.130 That email from Dr McDonnell to his colleagues read as follows:

Do we really need 90 slots a year for outpatient blood patches? That just doesn't sound right – are we using the correct needles for LPs? 3-4 months for a diagnostic LP looks too long.

14.131 Dr Craig's response was to suggest a consultant meeting. There is no contemporaneous note or other record of the consultants' meeting that has taken

place on 3rd November and no witness to the Inquiry ever referred to the meeting in their evidence. A decision, however, does seem to have been taken to reduce the blood patch procedure capacity to one per week. It is possible that there was no such meeting occurred but this would appear to be at odds with an email on 4th November, from Dr Harley to Dr Watt's secretary which copied in Dr Watt and stated:

I've been informed that following a consultant meeting yesterday it has been decided that there will now only be one slot available per week for blood patching.

The four patients currently booked will not be affected but the changes will come into effect from December 17th.

- 14.132 Responding to the reduction in capacity on 4th November 2015, Sister Vanessa Boyd emailed Dr Watt's secretary, Dr Watt, and Dr Harley. She copied in Ms Lundy and Dr Craig and noted that the impact on the waiting list for day case lumbar procedures was too great and only one blood patch procedure per week was to be accommodated. Sister Vanessa Boyd went on to state:

[Dr Watt's secretary] – I am unsure what arrangements you had already made re allocation of slots for blood patches, but this will now need to be revised.

Given the volume of blood patch referrals, I think that we will have to come up with another strategy for managing these – I realise that in the interim, they will just have to go on the waiting list.

Does anyone else do blood patches within the trust?

Can they be referred elsewhere?

[Dr Watt's secretary] – Can you please tell me how many patients are currently on the waiting list for blood patches?

- 14.133 Dr Craig responded on the same day to the dilemma:

This is something we need to think about. There is clearly an increased demand for this service. Certainly, I am very grateful to Dr Watt for his intervention in some of my patients with spontaneous intracranial hypotension.

- 14.134 Matters were again discussed at a consultants' meeting on 24th November 2015, at which the first item on the agenda was the impact of elective blood patch procedures on day case waiting lists/capacity for outpatient investigation in neurology. Notes of the meeting suggest that 8 consultants were in attendance. Dr Watt had sent his apologies. Dr McKinley appears to have asked where the blood patch referrals were

coming from and why there was an increase in demand. Dr Craig, noting that he himself had requested two in a year, estimated that there were 44 per year. The Inquiry was anxious to understand how there was such a dramatic increase in blood patch procedures, given the fact that there had been so few up until 2014.

14.135 In his evidence to the Maintaining High Professional Standards (“MHPS”) Investigation Dr Craig summarised the position at that time:

We had a consultant meeting on 24 November 2015. At that meeting we discussed the projected requirement for blood patching. We did a very rough calculation based on how many we each referred to Dr Watt per year on average and multiplying that number by the number of Consultant Neurologists. We estimated 2/Consultant/year for 22 Consultants which gave a rough figure of 44/year. That estimate aligned with our understanding at the time of how many were being done. Given that some patients required 2 treatments I directed that Dr Watt should not do any more than 2 blood patches per week.

14.136 Paragraphs [9] – [23] above highlight the approach of the consultants to SIH and their experience of same in their own practices. It would be fair to characterise the gist of that evidence as demonstrating that consultants came across the condition only rarely and, in some cases, on only a handful of occasions during their whole career.

14.137 The Inquiry Panel considered with Dr McDonnell, the Clinical Lead, the question of why there were so many blood patch procedures:

Mr Lockhart QC: If there was a huge increase, which there appears to be, then that would give rise to a certain number of questions. One of those questions might be: is there a problem with the needles?

Dr McDonnell: Yes.

Mr Lockhart QC: But there are a whole set of other questions, and what we are concerned about here is that they then go to this meeting, that you may or may not be in attendance.

Dr McDonnell: Yes.

Mr Lockhart QC: And various people say, ‘I have referred one person’, and, ‘I have referred two’. It seems to us still a very unsatisfactory answer to the questions that are being raised.

Dr McDonnell: There was a sense check at that meeting, from what I understand. I think the minutes of that meeting were taken by John McKinley. I think at least one colleague indicated that he was making such a referral, presumably for spontaneous intracranial hypotension, about three times per year. Somebody else indicated they were referring about two cases per year. I don’t know what

else was said verbally. John, in his follow up to me afterwards, indicated that there were number of other people at the meeting who also said they were making those referrals. Those were not referrals that I was making, so it was interesting to hear that. It wasn't in keeping with my practice but that was the feedback.

Mr Lockhart QC: I suppose the query I have with the feedback is, ironically, as I would see it, the sense check is what I almost term the 'back of a fag packet' complication. What we have been very impressed with, at times, is the almost empirical attitude that is taken by neurologists to detail, you can't go there until you go there, and suddenly you have this kind of much more, 'I've given him a few', and 'I've given him a few', and that seems to be sufficient. There is a kind of contradiction in my head to this.

Dr McDonnell: Certainly, the feedback I got from John after that was that our concerns weren't necessarily shared. There were other people who were making these diagnoses and making referrals on to Michael. I suppose the context is that there's lots of other things going on at the time.

- 14.138 The minutes of the 24th November 2015 meeting of neurology consultants indicated that there was to be an audit of day case procedures. None of the consultants who gave evidence to the Inquiry Panel were certain as to the outcome of this action point. However, some pointed to an audit subsequently carried out by Dr Fiona Kennedy, Neurology Registrar, which was completed nine months later in August 2016. This audit considered the patients undergoing all day case procedures in the PTU, except blood patch procedures. While Dr Kennedy's audit may have been beneficial in other areas, it was irrelevant to the presenting problem of an excessive number of blood patch procedures. The fact remained that there was no diminution in the number of blood patch procedures and the evidence suggested that the number of procedures was, in fact, increasing.
- 14.139 The email evidence suggested that the 'one patient per week' slot, taken from the registrars' day case list in the PTU, was completely insufficient to meet with the ongoing demand for blood patch procedures, as Sister Vanessa Boyd had warned. What, in fact, transpired was that blood patch procedures were carried out on a different day than the designated Thursday afternoon slot and continued to be done in other places as well as the PTU.
- 14.140 Patients were continuing to undergo blood patch procedures booked via Neuroradiology and carried out in DSU. On 16th December 2015, Dr Watt's secretary emailed Mr Frizzell about blood patch procedures that were booked in with neuroradiology.

14.141 Dr Watt continued to seek access to Ward 4E for patients he was unable to facilitate elsewhere, and on 19th January 2016 his secretary, having failed to secure additional capacity in PTU sought to have two procedures done on the ward: one blood patch procedure and one lumbar puncture. The lumbar puncture was facilitated on the ward and a DSU bed was secured for the blood patch procedure.

14.142 In addition to using the DSU, Dr Watt, during that time, was seeking to bring extra patients to the PTU, even though consultants had agreed that there would be only one slot per week on the Thursday afternoon in the PTU. In January 2016 Dr Watt's secretary and Sister Vanessa Boyd sought further a further two slots for Dr Watt every Monday morning, and were advised:

As long as Dr Watt has assistance, it can start from next week 25th Jan. However, as we are not holding spaces, you would just need to check our availability in advance before giving patients appointments (just in case we are fully booked and some Mondays due to staffing we close at 5pm).

14.143 Dr Watt continued to require additional capacity on top of the three weekly slots then allocated on a Monday and a Thursday. On 2nd February 2016, the PTU agreed to facilitate a further patient on a Friday. On 16th May 2016, Dr Watt's secretary enquired about the availability to carry out a further 2 blood patch procedures on 23rd May 2016, in addition to the 2 already booked in. This was accommodated by PTU and further similar requests came in.

14.144 Sister Vanessa Boyd, in her evidence, highlighted the pressure at that time, and again explained that this was particularly so for Dr Watt's secretary:

Mr Lockhart QC: One gets the impression that the chaos that you describe must have been a subject of enormous discussion, enormous concern.

Ms Boyd: Yes, it certainly was within the secretaries. I mean, I know [Dr Watt's secretary] was nearly having a nervous breakdown about the — because she got calls constantly from patients about them. I had several conversations with [Dr Watt's secretary] to look at, you know, who was the next in line when we were allocating appointments or whatever, and she was just overwhelmed by that. So, for her, she got the brunt of it, because they would've rung her — I wasn't the secretary — but I got the second-hand, you know, just from the —.

Professor Mascie-Taylor: From [Dr Watt's secretary]?

Ms Boyd: From [Dr Watt's secretary], really, and how she was managing and how she was going to manage them, because they were just torturing her with demands as to when they going to get their procedure done. I think she was very overwhelmed by that.

14.145 By 28th June 2016, Betty Boyd, the Ward Sister in PTU, advised Dr Watt's secretary:

We cannot accept any more than 2 at any time, as we are under pressure for our beds, this had been our original decision. Not sure how more got booked in.

14.146 In an email of 14th July 2016, Dr Watt's secretary emailed the PTU indicating that Dr Watt had spoken with Sister Vanessa Boyd with regard to doing extra blood patch procedures on Monday and had arranged for extra procedures to be accommodated, which could facilitate up to 4 patients.

14.147 In her fourth written statement to the Inquiry dated 9th September 2021, Ms Lundy highlighted that at that time, the PTU suspended all new referrals because it was so overwhelmed with other procedures apart from epidural blood patches. Ms Lundy stated:

By mid-2016 there was very considerable pressure on PTU. The email of 1 July 2016 at 15.23 demonstrates the various types of neurology procedures that were taking place in PTU by that time. The volume of Tysabri infusions (referenced from my 2015 initiative in the above question) were a significant issue, but it was the totality of the variety of neurology related procedures that led PTU to temporarily suspend taking on new referrals from the Neurosciences Service.

I have not been able to find further material that bears on the late June/early July 2016 issues relating to PTU. In the absence of documents to assist me I am afraid I, at this remove, cannot recall the discussions. However, I do not believe the discussions were about EBPs; the issue was the overall extent of the Neurosciences requirements on PTU capacity. I am providing the Inquiry with some emails from 2016 that illustrate that the context and the issue was wider than EBPs. From my email of 19 September 2016 at 18.37 it may be that a meeting between Neurosciences and PTU about the general issues of neurological referrals to PTU had not taken place up to that point. However, as I explained in my second statement, I was off for significant periods of time between February and September 2016 due to ill health.

14.148 The Inquiry Panel notes that all new referrals had been suspended for reasons, according to Ms Lundy, which had nothing to do with blood patch procedures. It is surprising that despite the increased pressure, the PTU was still facilitating extra blood patch procedures. The problem of their frequency seemed to have been obvious and apparent, but there was a disconnect between what was happening within PTU and what other managers understood was going on.

14.149 By August 2016, blood patch procedures continued to be booked in at an increasing rate. In one week, commencing 26th September 2016, there appears to have been a total of 6 blood patch procedures. In that same week, Dr Kennedy, who was, at that

time, the day case registrar for Neurology, indicated that she had only one room for lumbar punctures for the next five weeks, having received an email from Dr Watt's secretary for the weeks ahead. She asked Dr Craig, Dr McDonnell, and Dr McKinley whether she should be "*reducing the number of LPs those days or just going ahead doing 6 in one room in 3 hours*". Dr Craig immediately responded to this:

I think that until we are agreed, as a group, that blood patch patients should not be booked into slots, or one per week maximum. This is a new service that seems to have grown exponentially and which has not formed part of any bid that I am aware of. While there may be a need for service it cannot just happen, displacing core activity.

14.150 Dr McDonnell, in response to Dr Craig stated:

If 1 blood patch per week has been agreed, then that should be the rate – possibly 3 in the one week every 3 weeks. That is still a lot of blood patches – 50/yr. The w/l [waiting list] for LPs is bad enough. I don't suppose there is another room that could be used for blood patches such that there is no impact on the LPs [Lumbar Punctures]?

14.151 At a consultants' meeting on 27th September 2016, which was chaired by Dr McKinley and attended by Dr McDonnell, Dr Craig, Dr McMonagle and Dr Hunt, the issue of capacity for routine day procedures was discussed. The minutes recorded:

Following email correspondence from Dr Kennedy who is currently the day case registrar it is apparent that due to a lack of rooms in the Programmed Treatment Unit whenever blood patches are performed in one of the rooms this limits the day case registrar to one room to facilitate up to six-day case lumbar punctures on one session.

No dedicated funding is in place for a blood patch service. In order to try and reduce waiting times for routine procedures such as lumbar punctures it was decided to reduce the number of slots allocated to blood patches on a Thursday afternoon in the Programmed Treatment Unit.

14.152 It was agreed at the meeting that: "*Blood patches will be allocated a maximum of one slot which must be the last slot of the day on the Thursday afternoon list and are to occupy one room only*".

14.153 Despite the decision taken, the pressure to arrange the procedures continued. It is not clear whether there was any direct discussion with the PTU by the Clinical Director or any conversation with Dr Watt. In fact, the Inquiry has seen no evidence that this decision was communicated to anyone beyond those consultants in the room for the meeting.

- 14.154 Email evidence suggests that 2 blood patch procedures per week continued to be booked in the PTU. In an email of 17th October 2016, Dr Watt's secretary checked availability for 2 blood patch procedures for both 21st November and 28th November. This was immediately accepted by the Programmed Treatment Unit. At the same time, patients continued to be booked into Interventional Radiology for a blood patch procedure. There is no evidence the blood patch procedures undertaken in Interventional Radiology were considered by those at the meeting on 27th September. The Inquiry has not seen or heard any evidence of any engagement with Interventional Radiology by those who had decided to limit the number of blood patch procedures undertaken.
- 14.155 One obvious point to be made from the evidence analysed, is the disconnect between actions that were ostensibly taken by consultants within Neurosciences and the actual number of procedures which were occurring¹⁸. The initial decision to allocate one PTU slot on a Thursday afternoon for blood patch procedures did not come close to addressing the capacity problem. While Dr Watt was certainly aware of some of the relevant emails raising concerns about capacity and the number of blood patch procedures, it had a negligible impact on his determination to continue to offer the procedure to the point where Dr McDonnell described the increase as "*of epidemic proportions*" in an email to Dr McCarron in December 2015.
- 14.156 In a further illustration of the prevailing culture at that time, a TIA clinic secretary emailed Dr Watt's secretary on 7th November 2016 with a request for another blood patch procedure to be arranged for a patient, who had fainted before the procedure could be completed. The secretary stated: "*Sorry he is handing out blood patches like Smarties at this clinic*". It is also apparent, however, that apart from one email from a neuroradiologist in respect of one specific patient in March 2014, there is no evidence that any doctor questioned the utility or appropriateness of blood patch procedures with Dr Watt. Colleagues were aware that he was the source of demand for the procedure, but there was little curiosity about the reasons behind the dramatic increase.
- 14.157 The overarching concern continued to be one of capacity and not the frequency of the procedure. The practice of proceeding to a blood patch procedure, even if there was normal imaging, was also noted to be commonplace. It is the case, as pointed out by several neurologists and from the relevant medical literature, that even where MRI imaging shows no objective evidence of SIH, there can be sufficient grounds,

¹⁸ By clinical governance the report is referring to those doctors such as the Clinical Lead, Clinical Director, and Chair of Division and ultimately the Medical Director. On administrative governance the report is referring to the Service Manager, the Assistant Service Manager together with the Co-Director of Neurosciences and the Director of Acute and Unscheduled Care.

on the history and examination, which may justify a blood patch procedure. The evidence suggests, however, that this is comparatively rare, and many clinicians will want to be reassured by the imaging evidence before carrying out what can be a difficult procedure, and not without risk, as discussed at paragraph 102 above. In his evidence to the Inquiry Panel of 12th November 2018, Dr Peukert commented on the percentage one would normally expect to have demonstrated on an MRI scan prior to undergoing a blood patch procedure:

Dr Peukert: I escalated files. I didn't approve them and escalated and told also Dr Watt. I told him "Look, I don't agree with this diagnosis". I understand that some patients had normal MRI scans ... but out of so many patients none have an abnormal MRI scan, so you can have exceptions, but you can't have so many exceptions.

Professor Mascie-Taylor: You can't have that many exceptions otherwise your cohort of exceptions is greater than any international series. I will be really clear about that ...

14.158 In clinic letters seen by the Inquiry a frequent phrase appeared: "*Despite the normal imaging his/her symptoms remain suggestive of intracranial hypotension. I will arrange for him/her to be admitted for an epidural blood patch*". A similarly worded letter was, in fact, what prompted Dr Colin Fitzpatrick to raise the first concern about the use of the procedure in December 2016, and the practice was highlighted graphically when Dr Peukert began to review patients awaiting a blood patch procedure from December 2016 onwards. In this context, the Inquiry Panel again expresses its surprise that it was Dr Fitzpatrick and, at one stage, Dr Conn, both General Practitioners, who had greater concerns than Dr Watt's consultant colleagues.

14.159 There is also evidence that Dr Watt often either did not order MRI scans in cases of suspected SIH or proceeded to undertake a blood patch procedure in advance of it taking place or receiving the results. In an exchange of 28th April 2016 regarding a patient, Dr Watt's secretary emailed Dr Watt and Dr Catherine Donaldson, a registrar at that time, querying whether she should hold back the arranged blood patch procedure until the results of an MRI. Dr Donaldson directed her to do so, but on communicating this to the patient she was advised the patient was told by Dr Watt he was going ahead with it:

I have been in contact with this lady about her blood patch. I explained to her that she was to have the MRI first and then the blood patch. She is very confused as she said Dr Watt told her she didn't need the result of the MRI and that he knew what she needed.

14.160 Dr Donaldson responded: *“I just assumed the MRI was needed first to look for changes of intracranial hypotension but maybe Dr Watt doesn’t need it first”*. The Inquiry has not seen any response from Dr Watt to the email thread.

14.161 The documentation also highlights a significant number of outpatient letters describing problems associated with the procedure. In relation to one patient a letter from a clinic in January 2016 explained:

Since the epidural blood patch, she has had severe pain in her right leg which has now spread to affect both legs. She also has pain at the bottom of her back. The pain becomes really intense when she tries to sit up beyond 60° when rising from lying to sitting and since the procedure which was twelve days ago, she has spent most of her time in bed and has so far been unable to return to university.

14.162 A further example is in a clinic letter dated March 2016: *“the epidural blood patch has left her with a really sore back extending down into her left hip and both legs. Unfortunately, there has been no improvement in her jerking movements”*.

14.163 In addition, Dr Watt’s secretary emailed him in relation to a patient who had undergone a blood patch procedure on 11th April 2016:

Had blood patch 11/04/16. Since then, has been very ill with severe back pain (top and bottom), vomiting and can’t eat, has been very sick from it was done. Was at A&E on 15/04/16 due to symptoms.

14.164 One patient continued to report a range of symptoms following repeated procedures. After his second blood patch procedure he reported hallucinations, spells of altered consciousness and constant dizziness. He was shortly thereafter admitted to an acute mental health facility. After his third procedure Dr Watt noted in his clinic letter of July 2016 it had ‘left him feeling even worse’. On 23rd August 2016, he contacted Dr Watt’s secretary by phone, and she noted:

He says he is totally disabled with the pains in his head. They are there morning and night. He can’t stand with the pains in his head, and he cannot communicate with people or his children. They are tormenting him ... He is asking what do you suggest?

14.165 On 24th November 2016, an administrator emailed Dr Watt about a patient who had left a message on the answering machine. The administrator stated:

She said you did a procedure on Monday which I assume is a blood patch ... Don’t know if she is a pp¹⁹ or who she is but she said it’s made her headache worse which is why I think blood patch.

¹⁹ Private patient.

14.166 The following day the patient contacted the administrator again and she emailed Dr Watt stating:

I have had her on again. She wants to speak to you or for you to let her know what to do. [The patient] is in agony.

14.167 The key question for the Inquiry Panel is whether these issues of patient difficulty, post-procedure were brought to the attention of management and what if anything was done. The impression is that nurses, ward sisters and lower-level administrators were valiantly trying to liaise without great success with Dr Watt.

14.168 A potential reason for the lack of curiosity about, or challenge to, Dr Watt's practice in this area was a growing perception within Neurology at this time that he was the expert on SIH. In an email of 27th January 2016, Mr Philip Weir, Consultant Neurosurgeon, emailed advising a patient, who he thought may have SIH: *"It seems that the best person to see is Michael Watt, he has a few patients with this type of problem and has been doing blood patches on them with some effect"*.

14.169 A further example is contained in an email of 17th June 2016 from Dr Kearney to Dr Watt. Dr Kearney had already tried 3 lumbar epidural blood patch procedures a patient, who he suspected may have possible SIH. He thought it would be worth considering a targeted epidural blood patch at a higher level and noted to Dr Watt:

I referred her to intervention of radiology for this, but Dr Flynn has written to me suggesting I discuss this with you. Is this a procedure you would consider for this patient?

14.170 Dr Watt continued to operate on an independent basis. He clearly felt free to ignore decisions of his consultant colleagues and this was tolerated. Dr Watt was not in attendance at any of the consultants' meetings where these issues were discussed and seems to have had little interest in involving himself with such concerns. Nor did anyone managing him require him to account for the number of blood patch procedures he was carrying out, or the chaotic booking in and recording of the procedures.

14.171 It is in this context that the intervention of a local GP in a small practice is significant (as set out in the November 2016-May 2018 chapter). Granted, Dr Fitzpatrick was the local representative for NCAS, but he was not a neurologist and was still apprehensive about challenging a consultant in the first place. Nevertheless, he posed a straightforward and basic question regarding the need for a blood patch procedure in the absence of objective evidence to support SIH. Dr Fitzpatrick contacted the Medical Director's Office on 17th November 2016, acting in his role

as a patient's GP on behalf of his own patients and their diagnosis. Dr Fitzpatrick was then asked to deal directly with the Clinical Director, Dr Craig. He had an initial conversation on the telephone on 22nd November (with Mr Peter Watson from the Belfast Trust Medical Directors Office.) The cases raised by Dr Fitzpatrick did not include any patient who had undergone a blood patch procedure. On 5th December, however, Dr Fitzpatrick emailed Dr Craig stating:

I received this letter today from MW [Michael Watt] at UIC²⁰ (over a month after the clinic attendance).

I am not a neurologist, but it seems to me that he is saying that despite the complete lack of objective evidence to support intracranial hypotension, he is planning on transferring the patient to the NHS for an epidural blood patch. Maybe this is normal practice – I don't know.

This patient has consented to me contacting you about this and I can provide identifiers if required.

14.172 Subsequent to this, the then Medical Director, Dr Cathy Jack, emailed Mr Peter Watson, Senior Manager in the Medical Director's Office, Mrs Bernie Owens, Director of Acute and Unscheduled Care, and Dr Craig on 12th December 2016 as follows:

Further concern re diagnostic reasoning in a case of spontaneous intracranial hypotension presented for second opinion privately – potential patient safety issues as treatment has risks associated. Clinical diagnosis queried by second opinion and not supported by imaging etc.

1. Will need restricted practice without prejudice ie needs each spontaneous intracranial hypotension cases to be discussed with Thomas Peukert before proceeding with any epidural blood patches.
2. Needs all the cases of spontaneous intracranial hypotension diagnosed by MW [Michael Watt] reviewed by two neurologists. Not by the CD. Orla Gray and ? another from outside NI.
3. Need to alert the Medical Director in any private practice setting where MW [Michael Watt] may work.
4. Letter to be drafted for sign off tomorrow am.

14.173 On the following day, Dr Craig asset out in writing a concern in relation to a patient, whom he had consulted with on 12th December, and discussed with Dr Jack the previous evening. It is this case which is the subject of Dr Jack's email of 12th

²⁰ Ulster Independent Clinic.

December at [171] above. Dr Craig set out with care and particularity, his concern to the Medical Director, Dr Jack:

Subsequent to the concerns that have been raised by Dr CF [Colin Fitzpatrick] (GP) in regards to Dr MW [Michael Watt] and which have resulted in the commencement of a preliminary investigation and which has since included a fourth case of possible spontaneous intracranial hypotension (SIH) I have seen a woman who Dr W [Watt] has diagnosed as SIH and who has been treated with two epidural blood patches. This woman attended my private clinic yesterday. She was accompanied by her husband. She did not have a referral letter from her GP but wanted to have a second opinion on her diagnosis and treatment to date. While I have not had sight of her previous medical records after consideration of her history and physical examination and available investigation results and response to treatment, I was unable to come to the same conclusion as Dr W [Watt], being of the opinion that her symptoms and investigation results as available were not suggestive of SIH. The lady informed me that she has an upcoming appointment with Dr W [Watt] and that it is her understanding that further epidural blood patching is planned. While I fully appreciate that another neurologist may take an opposing view to that which I have expressed and that there may be additional information that would lead me to change my opinion and that I may not have raised any concerns, based on this case alone, if I had not been aware of the prior case, in my role as part of the preliminary investigation and fully accepting that that the diagnosis of SIH can be difficult, that it can present variably and that initial epidural blood patching does not always work, I am concerned that the treatment of SIH with epidural blood patching carries risk. I therefore require guidance on how to best proceed.

14.174 The following was apparent in the period 2015-2016:

- (i) Dr Watt was consulted both by colleagues in radiology and in neurology in respect of the blood patch procedure.
- (ii) Evidence of significant side effects and sequelae from the procedure was available but was not picked up on by any other doctor.
- (iii) Despite decisions made regarding the use of the Programmed Treatment Unit, Dr Watt successfully managed to book in sometimes up to 6 patients a week for a blood patch procedure.
- (iv) In the period between October 2015 and November 2016 there appears to be a disconnect between the deliberations of consultant neurologists and the actual effect on the booking of epidural blood patches.
- (v) It was the pseudomonas outbreak in Ward 4E, which raised concern among nursing staff and the Assistant Service Manager of getting day

procedures, such as the blood patch procedure, out of the ward. The concern highlighted the fact that so many blood patch procedures were taking place within Ward 4E. This then caused questions to be raised by, in particular, Sister Vanessa Boyd and Ms Clare Lundy on why there was such an increase in this procedure.

- (vi) Dr Watt continued to operate in a maverick way clinically and organisationally. Although the issue may have been brought to the attention of the Clinical Director, administrators and nursing staff, it is also apparent that staff were anxious to assist and accommodate requests for additional space to be made available outside the ward.
- (vii) While some colleagues expressed surprise at the sudden emergence of the incidence of the condition, no action was taken by anyone at consultant level to query in more depth, why there had been a dramatic increase in such procedures.

Events Post Restriction:

14.175 Dr Watt was restricted initially by the Belfast Trust in December 2016 by way of partial restriction and by full restriction in July 2017. No further blood patch procedures were carried out by him after July 2017 and the events post restriction are more fully analysed in the November 2016 - May 2018 chapter. The partial restriction imposed by Dr Jack on 13th December 2016 was set out in a letter to Dr Watt from Dr Jack of the same date:

When presented with any NEW cases which you consider is indicative of a diagnosis of spontaneous intracranial hypotension, you must discuss the diagnosis and treatment plan with a colleague at consultant grade; the details of who this will be provided to you urgently.

When presented with any REVIEW case which you have previously considered is indicative of a diagnosis of spontaneous intracranial hypotension, you must discuss the treatment plan with the colleague at 1 above.

14.176 One of the first implications of the partial restriction on blood patching procedures in December 2016, and subsequently, was the emergence of complaints from patients who had been due to undergo a blood patch procedure, but who were then deferred. One of the issues that arises is the extent to which the Trust should have communicated with patients who were expecting the procedure.

14.177 A complaint was received some days later from Francie Molloy MP, on behalf of a constituent. In his letter of 9th January 2017, Mr Molloy stated:

[The patient] advises that she has been informed that there are concerns over fluid leaking in or around the spinal area having been at a consultation in September 2016. Unfortunately, there is no indication of a timescale for further investigation or appointments.

14.178 This enquiry from an MP set off a flurry of email communication. Mr Frank Young was involved and suggested that Mr Atkinson, the Service Manager liaise with Dr Craig “*given the sensitivities around blood patches*”. The email from Mr Atkinson to Dr Craig highlighted the ongoing backlog, which appears to have been present since May 2015:

This relates to one of Dr Watt’s patients who is waiting on a blood patch. The lady was added to the waiting list on 14 November and there are about 30 patients in front of her. I understand that Dr Peukert is reviewing the list and that DSU are planning to book 3 cases in each Monday if given the go ahead.

14.179 The pressure clearly had some impact. Dr Peukert reviewed the private notes and was “*happy enough to go ahead with LP (lumbar puncture) if Dr Watt confirms that headache is getting worse when standing up.*”

14.180 There is no record in the emails of anyone speaking to Dr Watt at this time along the lines suggested by Dr Peukert, but Mr Atkinson sought confirmation of the appointment and Dr Watt’s secretary made the arrangements for the procedure.

14.181 The Inquiry Panel also received evidence that, during this period, other consultants were referring their patients to Dr Watt for an opinion on diagnosis and whether a blood patch procedure might be appropriate. On 29th November 2016, Dr Aidan Droogan wrote to Dr Watt stating:

Following our discussion today about [the patient’s name], thank you for agreeing to see her at your neurology clinic in the Royal Victoria Hospital. As I mentioned I believe there is a possibility that [the patient] may have a low CSF pressure syndrome and would be most grateful for your opinion on this diagnosis and whether or not a blood patch may be appropriate treatment for her.

14.182 D The patient referred in November 2016 by Dr Droogan was further reviewed by Dr Watt in March 2017. The original letter of referral had asked for Dr Watt’s opinion on whether a blood patch may be an appropriate treatment. Based on Dr Craig’s early clarification, this should have been a case that Dr Peukert would have reviewed. It appears, however, that Dr Watt was adopting the same approach as Dr Peukert in assuming that once a patient had been referred by another consultant that was effectively a *carte blanche* to carry out as many procedures as Dr Watt believed

appropriate. In a note prepared following consultation with the patient, Dr Watt stated:

I feel she might benefit from a lumbar epidural blood patch. I will arrange this for her. As she was referred by Dr Aidan Droogan we should be able to go ahead without any great delay.

14.183 This was a point commented on during Dr Craig's evidence:

Mr Lockhart QC: [Dr Peukert told us in his evidence], *'I was focused on those patients who Dr Watt was himself diagnosing. If other neurologists diagnosed, then that was not really a matter for me'*. The question I have for you is in your view, if another neurologist ... or neuroradiologist or neurosurgeon -- referred a patient in ... for a blood patch. On the basis that clinician had diagnosed SIH, as far as [Dr Peukert] was concerned, that was the end of the matter. Did Michael Watt have the authority once he got the patient once, to then carry out as many repeat blood patches as he wished on that patient, or was he supposed to, under the restriction, go and check with Thomas about a further blood patch?

Dr Craig: You will obviously see, from reading the emails, that we were learning on the job a bit here. There was the initial instructions, which were fairly clear, and which I fairly clearly communicated to Thomas [Peukert], but then it quickly became apparent, down to going back to the last point about the numbers that were being done, that it didn't take very long after we put the initial restrictions in place that a patient identified themselves from somewhere else. I think, in retrospect, it would have been far better if Thomas had to review, somebody had to review every one every time, because not only was there an issue here with the security of the diagnosis, but it is also apparent there was an issue in terms of his enthusiasm for doing repeated epidural blood patches, and what our mechanisms did not do was protect the patient against that. Undoubtedly that was a failing in the mechanism we set up. It is always difficult, at the best of times, to put absolutely watertight rules and regulations in place that will cover every eventuality, but that is a concern now that there may have been patients that came from somebody who had three, four blood patches, when it was apparent after the second one, they weren't getting better with that method of treatment.

14.184 There is no criticism of Dr Peukert for the mistake that was made. While Dr Craig had clarified at an early stage that there was a difference between an opinion being sought and a procedure being carried out, Dr Peukert did not have the benefit of the written restriction and had also been responsible for the systematic collation of those 130-140 patients he had reviewed. As stated above, it was this action which highlighted the extent of the blood patching problem more than anything else. The events, however, illustrate the difficulties with a partial restriction and

the critical importance of communicating effectively with all those charged with a specific responsibility. The manner in which the partial restriction was implemented ensured that once a patient had been or was referred by another consultant for any reason to Dr Watt, even for an opinion, then Dr Peukert had no involvement in reviewing the diagnosis of SIH. Further, as Dr Peukert made clear, once a patient had been referred by another consultant to Dr Watt, it was a matter for Dr Watt as to how many blood patch procedures should be carried out. This was something that clearly should have been discussed with Dr Peukert.

- 14.185 Dr Craig, in an earlier email had indicated to Dr Peukert that neurosurgical consultants would be in the same category as neurology consultants in relation to the approval of blood patch procedures. The point is, however, as illustrated by the referral from Dr Droogan, Dr Watt was being asked for his opinion. The restriction can only have meant that his opinion would be checked by Dr Peukert. Referral per se ought not to have afforded Dr Watt *carte blanche*. In practice, however, referral by another consultant was not checked by Dr Peukert. In his evidence to the Inquiry Panel, Dr Peukert stated that he did not consider the possibility that patients may have been referred to Dr Watt for an opinion on diagnosis and/or treatment, rather than simply as a technician to carry out a procedure directed by the referring consultant. The majority of referrals to Dr Watt viewed by the Inquiry involved a consultant asking for his opinion on the diagnosis of SIH or a query as to whether a patient required a blood patch procedure.
- 14.186 On 11th January 2017, a patient who had complained about Mr Gavin Quigley, Consultant Neurosurgeon, met with Mr Quigley and the then Assistant Service Manager of Neurophysiology /Neurosciences. The minute of the meeting highlighted the fact that Mr Quigley had discussed with his patient the merits of proceeding with a blood patch with Dr Watt, and their conclusion that this would be worthwhile. They agreed she would be reviewed by Dr Watt. In an email of 20th January 2017, Ms Westwood informed the patient that an appointment was scheduled for 2nd February with Dr Watt “*where he will assess and discuss re blood patch*”.
- 14.187 In a letter to the patient’s GP following the appointment, Dr J Anketell records that the patient was ‘referred by Mr Quigley for consideration of a blood patch’. Dr Watt’s views are recorded as follows:

Dr Watt discussed the procedure of a blood patch. Her symptoms are in keeping with a diagnosis of intracranial postural hypotension. He discussed the risks and benefits of this procedure and [the patient] is happy to proceed. We should be able to give her an appointment for a blood patch within the next month.

- 14.188 The Inquiry Panel notes that this patient appeared to have been referred to Dr Watt for his opinion. Certainly, from Dr Watt's perspective, the clinic letter conveys that this was a diagnosis he made and a course of treatment upon which he decided, not a direction or request from a colleague to merely carry out a technical procedure on their behalf. In the view of the Inquiry Panel, therefore, this case falls squarely within the restriction. Dr Peukert was provided with the patient's notes to review by Dr Watt's secretary but advised her, and subsequently Ms Lundy by email of 24th February 2017, that he did not need to get involved because the patient had been referred by a neurosurgeon. From Dr Watt's perspective, he had provided the notes for the person implementing the restriction to review, who had concluded the case did not fall within the restriction. The Inquiry considers Dr Watt was entitled to rely on this assessment, particularly in light of previous adaptations to the restriction in December 2016. Dr Peukert understood that his supervisory role was not required because the relevant decision making had been taken by Mr Quigley, rather than Dr Watt. The records suggest, however, that Mr Quigley was in fact deferring to Dr Watt and definitely not making the diagnosis or deciding upon the treatment course himself. This case is an example of where confusion as to the meaning of the original restriction is apparent.
- 14.189 The question also arises as to the wisdom of not discussing with other consultants the restriction. One can perhaps see a greater justification for circumspection at the beginning of the restriction when it was imposed. The full picture was not clear at that stage in December 2016. The picture, however, entirely changed when Dr Peukert's spreadsheet was compiled, detailing all his decision-making, and forwarded to Dr Craig in January 2017. It was at that point that the scale of the problem began to emerge and other consultants and especially Dr McDonnell should have been briefed. The failure to do so added to the confusion regarding the actual meaning of the restriction and highlights how difficult it is to implement a partial restriction and the need to manage the restriction and the MHPS process in a clear and unambiguous manner.
- 14.190 On 3rd January 2017, Louise Bell, a Deputy Sister in the RVH Programmed Treatment Unit, emailed Ms Clare Lundy as follows:

I have been asked by Dr Watt to check ACC's availability to book in blood patches. I had been informed by Sister Boyd before Christmas to not book any further in, as per request from yourself. Could you kindly advise if we OK to proceed?

14.191 Mr Gerry Atkinson, who had been copied into the email to Ms Lundy, emailed Dr Craig on the same day stating:

I had understood that further blood patches were not to be arranged. Is this the case?

14.192 Dr Craig replied within 25 minutes, as follows:

Blood patches can be done by Dr Watt, but only after cases have been discussed with Dr Peukert. Sorry, this is all so convoluted but there is a need to have as few individuals as possible being aware that there is an ongoing issue.

14.193 Several days later, Sister Vanessa Boyd contacted Mr Atkinson also looking for clarification. In her email, she stated:

I was looking at the PTL yesterday and there are at least 55 patients currently awaiting this [blood patch] procedure.

My understanding was that there was now a new protocol in place, and we could resume the bookings in PTU.

Please can you confirm same so that [Dr Watt's secretary] can start to book patients in where Betty [Sister Boyd] has capacity.

14.194 Mr Atkinson immediately responded to say that he understood a new protocol had been introduced and that appointments could be booked. Dr Watt was copied into all these emails. None of the emails accurately reflected the actual wording of the restriction.

14.195 At or about this time, the overlap with interventional radiology became more apparent. On 4th January 2017, Dr Graham Smyth, a Consultant Neuroradiologist, emailed the administrator, who was responsible for booking the image guided epidural blood patches within interventional radiology, as follows:

Would you be able to give me the 2015 and 2016 numbers for the targeted epidural blood patches we've done? Not sure if there's a code, and perhaps Keith could help. Some of them were done under CT, but most fluoro with Michael Watt. Could we also get CT myelogram numbers for those years?

Philip Frizzell had discussed putting a business case together for these previously as the injections were never quite funded as I understand it.

14.196 It is also clear at this time that interventional radiology was unaware of any restriction. On 20th January 2017, Alison Hart in Neuroradiology emailed Dr Watt:

What is your availability in the next few weeks for Blood Patches in Neuro?

14.197 Mr Philip Frizzell also confirmed to the Inquiry in a written statement that he was not appraised of any restriction, nor was he aware of Dr Peukert's role in relation to approval. Mr Frizzell was clear that he should have been made aware:

Yes ... restriction related patients were coming into the department I was responsible for. It is also the case that all Interventional Radiology imaging and treatment requests are approved by a Consultant Radiologist. If the Consultant Neuroradiologists had been informed of the restriction to Dr Watt's practice, then they could have checked to make sure that any Dr Watt related diagnosis had been approved in the manner required by the restriction.

14.198 On 5th January 2017, the request by Dr Watt's secretary for space within the PTU revealed that the capacity required for blood patches did not seem to have diminished. The email of 5th January stated:

Dr Watt has asked if there is any availability to carry out blood patches this coming Monday 9th January 2017. The plan is to try and carry out three blood patches using the one room. Blood patch appointments will be at 8.30, 10 and 12 midday. He was speaking to Louise the other day and she was to get back to him if this was possible or not. Can you let me know if this is possible, please?

Other than Monday 9th January can you also check for availability for Mondays 16th, 23rd and 30th January with the same arrangement of using one room with appointments at 8.30, 10 and 12 midday.

14.199 Further insight into Dr Watt's desire to continue the treatment at the same rate was provided by an interaction between Anne-Marie Hunter, a nurse who worked alongside Dr Watt, and Dr Watt's secretary, on 12th January 2017. Nurse Hunter confided to Dr Watt's secretary: *"Two patients for blood patches already. I can't do this anymore"*. Dr Watt's secretary immediately replied: *"mental"*.

14.200 It is important to note that Dr Watt's secretary, while carrying a significant burden of administration and working conscientiously on behalf of the consultant to whom she was assigned, had no responsibility whatsoever for the problems that arose. It is quite clear from the written evidence and her appearance before the Inquiry Panel that she at all times acted in good faith and sought to accommodate a workload which was above and beyond her duties as a secretary. Dr Watt's secretary deserves praise for her assiduous approach, and it would be entirely inappropriate to comment any further or to seek to even implicitly suggest that she had any responsibility for what transpired.

14.201 The first indication of disagreement by Dr Peukert came in an email of 11th January 2017. Dr Peukert emailed Dr Watt in the following terms:

I looked through the notes of [patient's name]. Based on them I struggle to make the diagnosis of low-pressure symptoms. I am aware that previous blood patches helped her, but I don't feel that this alone will justify blood patching. I suggest that I will see her on Monday morning to get history from her and will likely suggest MRI brain and spine ...I would hold blood patching at the moment.

Happy enough to go ahead with [patient's name].

14.202 On 20th January 2017, Dr Peukert emailed Dr Watt's secretary indicating that there was only one patient he could find for a blood patch. He went on to state:

Left some notes on your desk. I flicked quick through the notes in my office but there was nobody obvious for blood patch. Will look in more detail when back from leave.

14.203 Dr Peukert followed this up in an email to Dr Watt:

I looked through quite a lot of notes [Dr Watt's secretary] gave me regarding the blood patch situation. As we discussed it does not make a lot of sense to discuss every patient as you won't be able to remember the symptoms in detail and I would make anyway a decision based on the notes.

There will be a lot of patients where I was not able to see the indication based on the notes. I left the notes with [Dr Watt's secretary]. If you have additional details, you can let me know and I reconsider.

14.204 On the same day as Dr Peukert emailed Dr Watt, he also emailed the Clinical Director, Dr Craig to update him. This was the first occasion where a much clearer picture began to emerge of the number of people who were listed by Dr Watt to have a blood patch and the number who Dr Peukert did not feel had a clear indication. The email stated:

As there are so many patients on the waiting list Dr Watt is not able to remember the exact symptoms of individual patients when discussing with myself. For that reason, I looked through the notes and made a decision depending on letters/ECR.

So far, I looked in details through 20 notes (8 patients I saw myself). Out of these 20 patients I approved 7 for blood patch. I did not see any indication on the other 13. Nevertheless as [Dr Watt's secretary] and Dr Watt are keen to fill the blood patch clinic every Monday with 3 patients, I looked quick through another 49 notes to find a potential patient. I was not able to find a clear indication in any of the 49 patients but will look in more details when back from leave. These decisions are based on what is written in the notes/letters and ECR. As far as I can see so far only 1 patient out of 69 has findings of low-pressure headache on

MRI. Nevertheless, I have to review the 49 patients in more detail.

I am aware I should discuss the patients with Dr Watt instead of review[ing] the notes and the ones I approved were discussed. I will make Dr Watt aware of the ones I did not approve, and he can come back to me with more details if he feels it's needed.

14.205 In his evidence to the Inquiry Panel on 5th October 2020, Dr Peukert explained the growing realisation that there was a problem:

Dr Peukert: At the very beginning I discussed every patient with Michael Watt. I would get the first 10,15, 20, I went face to face and talked with him, and I said, 'look this patient'. I told him I don't think it is that, but he told me, 'You didn't see the patient'. I didn't see the patient. I only saw the notes. He saw the patient, so he felt he was right. So I was pretty quick, after four, five, six weeks, pretty sure that the numbers are not right, and I sent an email out saying that. I think there is an email somewhere where I saw 20 patients or so, and ten or so I didn't agree, or something like this. When you see the first patients you can think there might have been an exception. When I see the second one, maybe an exception as well. But it is after, three, four, five, six it became more and more clear that you don't have so many exceptions.

14.206 Dr Peukert was of the view that it was at this point that other neurology consultants should have been informed that there was a problem:

Dr Peukert: My opinion is that when I highlighted this the first time, after four, five, six weeks where I said that I don't agree with some diagnoses, at this stage possibly other neurologists, other neurosurgeons might need to be made aware if there is a problem to make the diagnosis. That is my opinion, but it is easy to say these things late on.

14.207 On 22nd January, Dr Craig sent the email received from Dr Peukert to Mr Young, the Co-Director in Neurosciences and commented:

Can we meet to discuss? Wait to see outcome but concerning.

14.208 On 24th January 2017, the then Assistant Services Manager emailed Dr Craig and Ms Lundy stating that there had been a couple of issues regarding blood patches and the handling of patients by Dr Watt's secretary. Dr Craig acknowledged the email and efforts were made to agree a time to meet. At a Neurosciences senior management team meeting on 24th January 2017 attended by Mr Atkinson, Ms Lundy, and Ms Westwood, it is noted in relation to the blood patch situation:

Blood patches. T Peukert providing second opinions. CL [Clare Lundy] to d/w J Craig re how to contact patients.

14.209 By 3rd February, the situation was becoming much clearer. Dr Peukert emailed both Ms Lundy and Dr Craig with an Excel spreadsheet and the following explanation:

I attach a table of blood patch patients that I reviewed. Not all of these patients will be on the waiting list as Dr Watt also brought patient to 4E or 2F and asked me to assess them there. This table was mostly for my own use so ignore the typos. You possibly just have to look at the column “blood patch indicated” and you will know who can be taken off the waiting list. It takes a while to look through all the notes but will keep you updated.

14.210 In February 2017 INI 399²¹ was booked in for a blood patch procedure by Dr Watt. He was confined in hospital for a period of 12 days. Dr Peukert assessed him on 2 occasions and advised an MRI scan. While waiting for the results of the scan, the patient experienced a VTE²². This was flagged as a Serious Adverse Incident, (“SAI”) but not until January 2018. Dr Peukert explained to Dr Craig in some detail on 7th February 2017:

I told patient that symptoms are well due to low-pressure, but the presentation was unusual. He had RTA [road traffic accident] in April 2016 and needed spinal surgery for that. 6-8 weeks later he developed symptoms like mild headache when standing, constant pins and needles, poor balance and dizziness when getting up. He had one episode of LOC [loss of consciousness] but BP [blood pressure] was ok. After I saw him the first time, I advised to perform MRI with contrast before blood patch. This delayed obviously his stay.

Dr Watt contacted me than to inform me that blood patch [sic – should read ‘MRI’] was done and normal. He asked me to review patient. I had long discussion with patient and wife telling them that although low pressure post-surgery is possible the presentation is unusual. Patient was aware that there was a good possibility that diagnosis was not low pressure, but patient had major problems to stand up due to symptoms.

I was happy enough to get blood patch performed as there was no other obvious explanation for symptoms.

The problem here was not the blood patch; the problem was the wait for the MRI, and I agree with Eoghan that this patient should have been covered with clexane or should have got MRI as O/P [outpatient].

14.211 The position of Dr Peukert personally was also becoming a matter of concern. He had started out offering to assist in what he believed would be a straightforward review of patients. In his statement to the Inquiry, he outlined his original expectations as follows:

²¹ This case is further commented upon in the Complaints chapter.

²² Venous Thromboembolism.

At that time there was no indication of the volume of patients I would be required to review. I thought it would be a relatively small amount of work, given that at that stage in my career I had not come across a significant number of patients who required a blood patch.

14.212 What became much more apparent in January 2017 was just how many patients were awaiting a blood patch procedure and how few of those patients Dr Peukert felt he could approve for the procedure. The Inquiry has no doubt that this was a development he did not anticipate. It is noteworthy that in his correspondence with Dr Watt, he is respectful and almost deferential. He was a relatively newly appointed consultant in neurology. He was challenging the view of a much older, more experienced consultant, under whom he had recently trained. At his own initiative, he decided to draw up a spreadsheet of each case that he assessed and reviewed. This was added to as further cases were considered. He acted in the most professional manner and the Inquiry is fully aware of the fact that in refusing to approve most of the blood patch procedures proposed by Dr Watt, he was attracting inevitable complaints from patients. For someone who had never had a complaint made about his medical practice, it would have been particularly galling to receive complaints essentially because one was willing to review a colleague's work

14.213 Dr Peukert, in the view of the Inquiry Panel, is deserving of the highest praise. Undoubtedly, it was his action in carefully collating and recording the cases he was being asked to review which provided the evidential framework for further action to be taken.

14.214 In addition to the exposure to potential complaints, Dr Peukert also had to devote a great deal more time to this exercise than he originally anticipated. This is picked up on by the Clinical Director, Dr John Craig, who directed that Dr Peukert's job plan should be amended to allow for an extra 1 programmed activity unit for the work that he was doing in respect of the blood patch review. Dr Craig was also anxious that Dr Peukert would not be burdened with the responsibility of letting patients know that they may not be receiving the treatment promised or in advising them of a delay. In an email of 3rd February 2017, Dr Craig stated to Dr Peukert:

We in Neurosciences Office, NOT YOU, will need to let patients know. They are likely to wish to discuss with someone.

14.215 It was apparent to the Inquiry Panel that Dr Craig was exercised by the burden of responsibility that had been voluntarily accepted by Dr Peukert. In his evidence to the Inquiry Panel of 5th November 2020, Dr Craig stated:

Dr Craig: He was exposed. Thomas, because of the role we had asked him to

undertake, got exposed to the difficulties much earlier than the rest, but it is unlikely you would find any neurologist who hasn't been traumatised by the process of the recall. The number of complaints went through the roof. Thomas was exposed for a number of reasons. First of all, he came at earlier than the rest of us, and certainly in terms of the diagnostic accuracy he was picking up the area with the lowest hit rate, plus he's really the only person within the department to do that. If there had been lots of MS cases, which there were, at least there are two or three colleagues that can share that cohort.

- 14.216 The Inquiry Panel notes that throughout the initial stages, Dr Peukert attempted to keep Dr Watt apprised of his developing views. On 15th February 2017, he emailed Dr Watt as follows:

Hi Dr Watt

I looked through quite a lot of notes / letters of patients regarding blood patches. Mostly I was not convinced that a blood patch would help. Nevertheless, this decision was based on the letters / notes, and I did not see a lot of the patients myself. I gave the notes back to [Dr Watt's secretary] who has a box of these patients. I did make John Craig aware of the problem regarding follow up on these patients. Obviously, you feel that SIH causes symptoms, and you possibly feel that you are restricted in managing these patients.

I am aware that seeing and talking to a patient can give you a very different impression, but as you know I can't see all these patients and have to decide based on notes.

Thomas

- 14.217 A revised Excel spreadsheet was forwarded to Dr Craig on 16th February 2017. This spreadsheet had been preceded by an email on 15th February to Dr Craig with an update:

Just an update on the blood patches. Based on the letters / ECR, I did not approve vast majority for blood patches. Notes go back to [Dr Watt's secretary] who takes them off the list as far as I know. I emailed Dr Watt to make him aware that there is a box with [Dr Watt's secretary] with not approved blood patches. Not sure how these patients will be followed up and I discussed this with Claire Lundy who possibly will come back to you.

All in all, it is much more time consuming as I thought, and I manage about 10/week. I do feel an additional PA would be appropriate as I stay quite often longer for that reason. Dr Watt seems to continue with his plan of performing blood patches and that does not make it easier.

Hope that's ok.

14.218 The question of confusion around the actual restriction itself becomes more apparent when one considers some of the specific cases, which were referred by other consultants. In his initial clarification, Dr Craig made a distinction between another consultant asking for a procedure and a consultant asking for an opinion. In the former instance, it was assumed that the diagnosis had already been made by the consultant and that a procedure was being requested. In the latter instance, a consultant was asking for an opinion on SIH and at that point, the restriction on Dr Watt's practice would apply. Dr Peukert was not, however, given a copy of the actual restriction. Although he ended up reviewing between 130-140 patients, he only reviewed those patients who had not been seen previously by any other neurologists. He told the Inquiry Panel on 12th November 2018:

I reviewed 130, 140 patients, something like that, but I only reviewed the patients that hadn't been seen by any other neurologists. There were on top of this, patients where neurologists or neurosurgeons felt this might be the diagnosis and referred the patient to Dr Watt for a second opinion and he then decided okay, that was what it is. I didn't get involved with these patients. I don't know how many of them there were.

He followed this matter up in his evidence to the Inquiry Panel on 5th October 2020:

I wasn't aware there were patients for opinions, and I didn't think about this. It wouldn't come to me. I only picked it up later on when he wasn't working any more, then these patients showed up and I realised actually the diagnosis was wrong, and there might have been blood patches performed because Michael Watt was asked for an opinion by another neurologist or a neurosurgeon, I think the diagnosis was not intracranial hypotension, but a lumbar puncture might have been performed because I wasn't involved.

14.219 A further feature at this time was the constant enquiry by patients to whom it had been suggested by Dr Watt that they required a further blood patch procedure. On 13th February 2017, Dr Watt's secretary emailed him as follows:

This lady rang today to let you know how she is. She says she has now had four blood patches and she is still not good. She says that you said the next step would be a targeted blood patch.

Can you advise please?

14.220 The same patient rang again in March wanting to know what was happening. Another example is a patient who had contacted Dr Watt's secretary on 2nd March. The note to Dr Watt stated:

This man rang. He was on the WL for a blood patch back in June but wanted to wait until after his MRI scan. He had his MRI scan in August but has not heard anything. He is looking to know now should be go on the waiting list for a blood patch (which he would be keen to have). He says he will also send you a text about this as you gave him your mobile number back when he first saw you.

Can you let me know so I can ask Thomas to take a look at his chart?

14.221 This patient followed up on several occasions looking to find out what had happened. The general atmosphere was one of numerous patients seeking further blood patches or consultations with Dr Watt. This created, of itself, confusion for patients, who were left in limbo and there was a distinct lack of communication with the Trust.

14.222 At that time, Dr Peukert was continuing to update his Excel spreadsheet. On 9th March 2017, he emailed Dr Craig and Ms Lundy:

Here is a list of blood patch patients that I did assess so far. I approved the red highlighted patient. On the green patient I wait for an MRI. The other ones are not approved and needs to be sorted. As I mentioned before it might well be possible that the decision not to perform a blood-patch changes after history from patient was taken.

14.223 Of the 87 patients reviewed by Dr Peukert and set out in the spreadsheet, 12 were approved and 1 was awaiting the result of an MRI scan.

14.224 On receipt of the spreadsheet on 16th March 2017, Ms Lundy queried with Mr Atkinson and Dr Craig as to what should be done with patients who had not been approved for the procedure and requested that it be discussed at the next Clinical Leads meeting. The note of that meeting of 16th March records: *'Review of cases completed' [John Craig] to d/w (discuss with) C Jack'* and subsequently *'Dr Craig then forwarded the spreadsheet to Dr Jack'*.

14.225 The spreadsheet was forwarded on 16th March 2017 to the Medical Director, Dr Jack. In his covering email, Dr Craig stated:

Dr Peukert has been reviewing those patients awaiting epidural blood patching. He informs me that he still has at least another 15 cases to review. Of the 87 that he has reviewed he has opined that 12 meet criteria, 1 needs further information and the rest do not meet with criteria based on information he has been provided.

We obviously need plan for how to move forward. In essence 74 patients have been informed by Dr Watt that they should have this treatment and they will not now be receiving it. Some have already been asking about when it will be taking place and what is the delay.

Can I please have steer on how to progress? I suspect some of us need to meet.

14.226 Dr Jack responded on the same day as follows:

We do need to meet and discuss. The numbers appear to be substantial. I suggest that we see if we can meet early next week to discuss our next steps.

Thanks again for all your help with this.

14.227 Although January was the first clear sign that there was a major problem with blood patch treatments, March 2017 was also a critical phase in the evolving understanding that Dr Watt was proposing blood patches in many instances where the diagnostic criteria and relevant tests did not justify the treatment. By 16th March, Dr Peukert had indicated that 14% of the patients proposed for undergoing a blood patch procedure had been approved by him on reviewing the relevant notes. Dr Craig, on receiving the most up to date evidence, immediately informed the Medical Director, Dr Jack, who, on the same day (16th March) suggested that a meeting needed to be held to discuss next steps.

14.228 At the same time as the full extent of the problem was coming to light, Dr Stephen Hunt, who had a limited understanding of the partial restriction, had been approached by Dr Watt at UIC. The initial approach from Dr Watt had been at the beginning of 2017. Dr Watt asked Dr Hunt to review some of his patients to see if there was agreement about diagnoses. Dr Watt did inform Dr Hunt, in general terms, that there was a restriction, but he did not make him aware of the details. Over the coming weeks, Dr Hunt saw approximately 5 people whom Dr Watt had diagnosed as needing a blood patch procedure. After consulting with the patients, Dr Hunt formed the view that there was “*a deviation from the expected norm*”. Concerned about these developments, Dr Hunt decided to speak to the Service Manager, Mr Atkinson. On being unable to find Mr Atkinson, Dr Hunt then spoke to the Divisional Director, Mr Young. The evidence in relation to the various interactions with both Dr Watt and Mr Young is set out in the Concerns chapter.

14.229 Following on from Dr Hunt’s meeting with Mr Young on or about 27th March, Mr Young emailed Dr Hunt in the following terms:

Following our earlier conversation, in John’s absence I spoke with Mark Mitchelson our new appointed Chair of Division who agreed with me that you should not be undertaking any referrals from MW for blood patches.

John, Mark and myself will meet with Michael just as soon as diaries allow when John gets back to clarify matters.

I did make clear to Mark that our conversation was an off the record informal one.

Hope this helps but if there's anything in the meantime don't hesitate to get in touch.

- 14.230 Dr Hunt emailed Mr Young the following day and indicated that he would speak with Dr Craig so that he knew his position. At or about this time, Dr Craig had been off work at various times because of a family bereavement.
- 14.231 The Inquiry has been able to piece together from a subsequent email of 17th May that a meeting took place with Dr Watt to discuss the Dr Hunt issue on 13th April. There is, however, no record of that meeting. It does appear that Dr Watt was spoken to and that Mr Young and Dr Mitchelson and, in all probability, Dr Craig were in attendance. Recollections, however, are very poor regarding this meeting, but what is apparent is that the matter should have been raised with Dr Jack, as this was a clear breach of the partial restriction.
- 14.232 When he first appeared before the Inquiry Panel, Mr Young had no satisfactory explanation as to why he had not brought to the attention of the Medical Director the situation with Dr Hunt and what appeared to be a clear circumvention of the partial restrictions. When recalled on the 2nd April 2021, Mr Young, the Co-Director, having reflected on the matter, believed that he would have brought it to the attention of Mrs Owens, the Director of Acute and Unscheduled Care, his line manager. He described instances where sensitive matters had been previously discussed. Mr Young also highlighted the fact that, in his belief, Dr Hunt had spoken to him on 27th March on what might be described as an 'off the record' or 'confidential' basis.
- 14.233 Dr Hunt was quite clear that, as far as he was concerned, he was raising the matter with an appropriate member of management and, while he did not contradict Mr Young's description in an email of the meeting as an informal off the record conversation, he did not think that the matter was in any way confidential. Dr Hunt's evidence is supported by the fact that he had indicated he would be speaking to Dr Craig about the matter. The Inquiry Panel accepts that Dr Hunt had no intention of restricting Mr Young as to how he should subsequently deal with the matter. While it is certainly possible that Mr Young could have mentioned his conversation with Dr Hunt to Mrs Owens, the Inquiry Panel does not believe that he did so or did so in a manner which effectively brought home to Mrs Owens that this was a significant breach of the partial restriction.

- 14.234 What is conspicuously apparent throughout this period from December 2016 to the end of June 2017, is Dr Watt's persistence in continuing with the treatment of patients with blood patch procedures and the acceptance by the Trust of this persistence. Most of the patients (circa 84) were on a waiting list for the treatment, but there were also an unspecified number of additional blood patches carried out despite the partial restriction imposed in December 2016. Further, Dr Watt's determination was not blunted by the findings of Dr Peukert, who had, with the full knowledge of Dr Watt, refused a substantial majority of all patients whom he had reviewed following Dr Watt's initial diagnoses.
- 14.235 What is further evident throughout this period from December 2016 to the end of June 2017 is Dr Watt's continued diagnosis of SIH and intention to use blood patch procedures at the same rates as prior to the restriction. His persistence was not blunted by Dr Peukert's findings, who had, to Dr Watt's knowledge, refused to approve the substantial majority of blood patch procedures proposed. Many of the patients reviewed by Dr Peukert were on a waiting list at the time the restriction was imposed, but Dr Peukert reported the difficulties he faced in managing the workload as Dr Watt continued to add new patients to the waiting list. In the Inquiry Panel's view, this is suggestive of a lack of self-reflection on Dr Watt's behalf which did not appear to cause concern for the Trust
- 14.236 The clinic letter regarding one patient at that time, on 30th March 2017, stated:
- She may seek a second opinion from one of my colleagues in the Ulster clinic and if they are in agreement, I may then be able to proceed to epidural blood patch. I will see her again in a few months.
- 14.237 At or about this time, Dr Watt's secretary also sent a blood patch waiting list to Dr Craig, which revealed that between 9th June 2016 and 9th March 2017, a period of 9 months, a total of 178 people were added to the waiting list for a blood patch, of which 143 were patients due to receive their first blood patch. By any comparable standard, this is a remarkable number, but Dr Watt did not appear to be in any way alarmed, despite Dr Peukert's failure to approve most of his requests.
- 14.238 In April 2017, four months after Dr Watt's secretary first queried how patients who were not approved for the procedure should be communicated with, the first draft of a letter to patients was circulated by Dr Craig and eventually forwarded to the Medical Director's Office. No general communication took place with patients, however, until November 2017 although there were individual replies to politicians and others who wrote directly to the Trust. Dr Craig's April draft stated:

Further to your appointment with Dr Watt, Consultant Neurologist and the plan for you to have an epidural blood patch we are writing to inform you that we are presently undertaking a review to determine if all of those patients who have been offered this procedure meet with the generally agreed criteria for diagnosing the condition and as such would likely benefit from having the procedure undertaken.

Once the review has concluded we will provide you with an update on how your management will proceed. We apologise for any distress caused by the contents of this letter or any delay to your treatment.

- 14.239 Various iterations of this draft were considered by Mr Young, Dr Mitchelson and by Dr Jack on 13th April 2017. On 14th April, however, Mr Young emailed Dr Jack, Dr Craig, Mr Watson and Dr Mitchelson and raised concerns:

I have shared and discussed the letter with John and Mark which generated a number of queries a few of which are listed below, however the main concerns are the time it is going to take to complete review which potentially could be 150 to 200 hours work so need to collectively agree who should be involved in this exercise and also who should act as the point of contact for patient queries which itself will be very time consuming?

Does the Trust want to mention Michael by name?

Do we need to alert GPs in advance that this letter is coming and how might they react?

Should John be signing the letter on behalf of the Trust?

Based on the above we felt a meeting with you would be helpful to agree how best to proceed so I will look to organise this after the Easter holidays.

- 14.240 The fact that it took almost a full year from the restriction being imposed for the Trust to write to patients or their GPs is indicative of confusion. The Trust appeared to believe they had to await a further ‘complete review’ of all cases where blood patch procedures had been undertaken or planned by Dr Watt before communicating with those patients Dr Peukert had not approved for the procedure. A decision about each patient’s care had been taken on the basis of Dr Peukert’s assessment. Patients who were not getting the procedure should have been advised so simply and promptly. Instead, they were left either believing they were on a waiting list for a procedure they were unlikely to get, or at best, having a follow up appointment with Dr Watt, who continued to believe they required a blood patch procedure.
- 14.241 The Inquiry Panel does appreciate that this was an evolving situation, but by the middle of March 2017, there was more than sufficient evidence to conclude that a

pattern had developed, which was aberrant, and that further action needed to be taken. Patients seem to have been the last people to be informed and this would have caused anxiety and confusion for them. While good decisions were made at that time, including the procurement of an independent report from the RCP and, the request to Dr Peukert to approve proposed treatment, the lack of communication with patients was a failing.

- 14.242 As noted above it was not until November 2017, some 11 months after the initial spreadsheet prepared by Dr Peukert, that a letter to patients due to undergo a blood patch was finally sent. The issue is considered again in the November 2016 - May 2018 chapter, but the regular email traffic throughout the summer months of 2017, suggested that in composing the relevant draft, the essential point was missed. Dr Peukert had reviewed the cases and found that in most instances a blood patch procedure was not justified because the diagnosis of SIH was not secure. The fact that another neurologist had decided that the proposed treatment was inappropriate should have been made clear in communication with patients. In contrast, the various drafts promised a review and apologised for a delay in treatment.
- 14.243 On 6th April 2017, at the Clinical Leads meeting, the Clinical Director, Dr Craig requested a retrospective review of blood patch procedures over the past 5 years. It was apparent that Ms Lundy made efforts at that stage to begin to quantify more accurately the extent of the problem. At the same time, however, neuroradiology continued to ask if Dr Watt was available to carry out blood patches, which had been booked for 4th and 18th May.
- 14.244 Dr Smyth agreed with the Inquiry Panel in his evidence of 30th March 2021, that neuroradiologists should have been informed of the restriction that was in place.
- 14.245 In an email of 26th April 2017, Ms Alison Hart emailed Dr Watt to ask about his availability. Ms Lundy became aware of this and emailed Alison Hart and Jenna Montgomery on the following day. Ms Lundy stated:

I would be grateful if you would please forward me the names of all patients who have had CT guided epidural blood patches in the last five years. I also require the patients H&C, date of procedure and the consultant performing this procedure. I would be grateful if this information could be shared with me as soon as possible.

No further CT guided epidural blood patches should be arranged without prior approval from the Neuro admin office.

14.246 Ms Hart responded immediately and enquired as to whether the blood patch procedures that had been booked needed to be cancelled. She also asked for the background behind the particular concern. Ms Lundy had already checked with Dr Craig who had confirmed that the procedure booked on 4th May could not proceed unless it was put through the agreed process overseen by Dr Peukert, and so she emailed Dr Peukert to ask whether it was appropriate. Dr Peukert was not in a position to confirm if a blood patch procedure was indicated as he was not able to review the patient's file and the procedure was cancelled. Mr Young, having been contacted by Ms Lundy, emailed Dr Craig and Dr Mitchelson enclosing a copy of the email from Ms Lundy regarding the patient on 4th May. Mr Young stated:

As per Clare's email Michael had booked a patient for a CT guided blood patch for 4th May. This would have gone ahead had the secretary not alerted Clare. We will need the Medical Director's advice on what actions now need to take place.

14.247 Mr Young contacted the Medical Director the following day and Dr Jack replied on 7th May in the following terms:

It is clear that Michael has not complied with the restriction regarding this case.

I think he needs to be met and this case discussed with him and the reasons for non-compliance explored.

Following this and your feedback on his reflections I will consider next steps.

14.248 A meeting subsequently took place on 16th May 2017 with Dr Watt, Dr Mitchelson and Mr Young. The issue of a patient being referred for a CT guided blood patch procedure was discussed. A note of the meeting was drawn up by Mr Young and forwarded by email to Dr Mitchelson on 17th May 2017. The note recorded that Dr Watt had stated that he was in full compliance with the restrictions currently in place. He indicated that the patient in question, who was due to undergo the procedure on 4th May, had been sent to Dr Watt by Dr Raeburn Forbes some years previously. As such, therefore, Dr Watt believed that once a patient had been referred on the first occasion, that subsequent blood patches could take place without the approval of Dr Peukert. Mr Young agreed to follow up on this and report back. The note also highlighted the issue with Dr Hunt, who had contacted Mr Young on 27th March, after being asked by Dr Watt to approve private patients for a blood patch procedure (see above at paragraph [228]). This issue would appear to have been discussed with Dr Watt on 13th April 2017. Mr Young recorded a minute of the meeting:

Mr Young raised the issues of blood patch referral continuing to be forwarded by Dr Watt to Dr Stephen Hunt when both were working in private practice at the Ulster Independent Clinic. Since the meeting of 13th April Dr Watt confirmed he had not forwarded any further requests since the meeting and that these must be the remainder old [sic] referrals continuing to trickle through. Dr Watt again confirmed that he was in full compliance with the restriction letter issued by the Medical Director in December 13th.

Dr Watt stated that he was very frustrated with the restriction process and felt that no other Neurologist or Neuroradiologist had his level of expertise and that he reminded [sic] best placed clinically to determine which patients would benefit from a blood patch procedure.

Mr Young offered Dr Watt an Occupational Health referral, but this was robustly declined.

14.249 The fact is that Mr Young was aware that Dr Watt had not been in full compliance with partial restriction. He in fact had the meeting with Dr Watt because he was not complying and as a result of Dr Hunt's intervention. The matter should have been immediately escalated without delay.

14.250 Efforts were then made to try and understand whether the patients from neuroradiology were 'self-referrals', as opposed to from other neurologists. The problems with a lack of clarity on the actual restriction began to accumulate. The perception that the partial restriction did not apply to a patient who had been referred to Dr Watt by a neurosurgeon in September 2015 – 15 months before the restriction was implemented – and on whom Dr Watt had performed 3 epidural blood patches in the interim led to the scenario that there was no restriction on the number of blood patches that could be carried out on an individual patient. This provided no reassurance that the partial restriction was effective in each case.

14.251 At this point, Mr Watson, who had been asked to follow the matter up, emailed Mr Young and forwarded to him the original letter of restriction of December 2016. Mr Watson stated:

When the requirements are laid out, I cannot see what difference it would make that the referrals from [sic] other Neurologists.

14.252 Dr Jack emailed Mr Watson in response to the email trail on 30th May 2017 and stated as follows:

I am responding given the email trail below. I have not been party to any recent discussion.

Thank you for the below. There is no concern about Dr Watt's technical ability to perform the procedure, nor are there concerns about any other neurologists and their use of the diagnostic criteria.

The information I received below was that Michael had been the diagnosing consultant for the case he had subsequently referred. If this was another consultant, and Thomas now believes that the diagnostic criteria was not met, then I think that we now need to establish if John has any concerns about other colleagues regarding diagnosis.

14.253 On 31st May, Dr Craig emailed Dr Jack and copied in Mr Watson, Mr Young, Dr Mitchelson and Mr Atkinson:

Dear Cathy

I have no concerns regarding any of the other neurologists' ability to diagnose spontaneous intracranial hypotension. I obviously cannot vouch for myself.

14.254 In her response, Dr Jack stated:

Thanks John. I thought this was the case. I just wasn't sure from Peter's email if there were no issues, given Frank's original email.

Cathy

14.255 Dr Craig replied:

Cathy

None whatsoever ... Let me know if there is anything I can do.

John

14.256 It is particularly disappointing that the incident, therefore, with Dr Hunt, which was a clear breach of the restriction, was not brought to Dr Jack's attention at this stage. Dr Jack only became aware of this development when papers were sent to her by the Inquiry.

14.257 In the view of the Inquiry Panel, the failure to escalate the concerns raised by Dr Hunt to Dr Jack in March/April 2017 was a significant omission. Primary responsibility for this rests with Mr Young, who, as a Co-Director of the Division, with enormous experience, should have recognised the importance of the breach and the impact that it would have had. Dr Mitchelson also must bear some responsibility, although the Inquiry Panel accepts that he had been in post for a limited period of time and was not the person to whom Dr Hunt had originally spoken. Nevertheless, it was incumbent upon him to ensure that, following his meetings with Dr Watt on 13th

April and 16th May, the Medical Director was fully appraised of the situation. Dr Craig must also have been aware of the situation. The Inquiry Panel recognises that he was not at work for at least a part of the critical period and did not, for instance, attend the meeting on 16th May. His memory of this incident is limited, but he did accept that he would have known. In part, he was entitled to rely on both Dr Mitchelson and Mr Young, but there were other meetings with Dr Jack where, in the Inquiry Panel's view, Dr Craig should have raised with Dr Jack the matter referred to Mr Young by Dr Hunt.

14.258 On 3rd July, Mr Young wrote to Dr Jack in the following terms:

Cathy

As per Gerry's email did John Craig speak to you about the cohort of patient's who MW had felt might benefit from having a blood patch?

We have received an MLA letter about this particular patient (attached) which Thomas deemed did not require a blood patch.

Gerry is off until Wednesday (TOIL for Service Manager On-Call) but just wanted to bottom out with you as John's on leave and out of the county did you agree a form of works these cohort of patients were to be given?

Happy to draft something if you prefer?

Thanks Frank

14.259 Dr Jack responded on the same day:

Frank

I heard nothing more after we sent a draft to you and John sometime ago? Before Easter. From memory I had asked for confirmation if the letter to GPs and patients had gone.

Mark and you were going to pick up.

Copied to Bernie and Peter as I am off this week.

Cathy

14.260 Dr Jack followed this up on 11th July 2017 in an email to Dr Mitchelson, copied to Mr Young when she asked if the letter had gone to patients. Mr Young responded to this. It appeared that the view was taken that all patients would need to be checked as an essential first step before the letters could be released. Mr Young stated to Dr Jack:

Cathy,

Unfortunately, the validation exercise has been a much greater task than was anticipated.

I have been working very closely with Clare Lundy and the then Asst. Service Manager (Gerry is on annual leave) who in turn have been liaising with the admin team to check and verify MWs Blood Patch waiting list with those Thomas reviewed.

It appears these differed so double checking was required to ensure no patient was overlooked. This is almost complete – definitely by Friday morning but in the meantime, letters have been typed ready to be issued to GPs and patients immediately the validation is completed. There are a small number who Thomas has confirmed would benefit from this procedure so depending if Michael returns to work next week, we may have to look to another Neurologist to follow up on these.

I'm finishing myself today Cathy until 24th July, but Clare will be working closely to Mark to ensure proper procedures and processes are adhered to.

Frank

14.261 By 14th July 2017, Ms Westwood had collated the spreadsheet prepared by Dr Peukert and, in an email to Dr Mitchelson, Dr Jack, Mr Watson, Mr Young and Dr Craig, she highlighted the outcomes:

- 84 patients referred for BP, reviewed by Dr Peukert, not approved but remain on Active waiting list.
- 14 patients referred for BP, reviewed by Dr Peukert, approved and remain on active waiting list.
- 12 patients on active blood patch waiting list who will require a review of case by Dr Peukert.
- These cases will need to be confirmed with Dr Peukert upon his return next week.
- 9 patients not on active waiting list but were referred for BP – it is unclear if this has been communicated with patients.
- Again, these cases will need to be confirmed with Dr Peukert upon his return next week.

14.262 A few days later, Ms Westwood emailed Dr Craig. She stated that she understood that he had not reviewed the proposed drafts as they had evolved. Some days later, Dr Mitchelson indicated that they needed to meet and that the drafts couldn't

be finalised until the meeting with Dr Watt. On 19th July, Ms Westwood wrote a detailed email to Mr Atkinson and Ms Lundy. In relation to letters to patients, she explained the chronology at that point as follows:

Subsequently, there was a meeting yesterday with Mark Mitchelson, John, Gavin and myself. John (and Gavin) felt that the patient letter in particular should be signed by Cathy Jack. He was happy for both his and Frank's name to be included in contact details for the GP letter and for him to sign the GP letter.

Both drafts have now been amended and are with Mark, who is discussing the signature with Cathy and also the issue re: timeframe for completion of review, to be included in patient letter – Peter W is being asked to give an indication for this.

Mark has also advised that the letters are to be passed by Michael, whom he is meeting tomorrow afternoon (Thurs) along with Peter and (MPA rep).

Therefore, until this has all been decided, the letters remain on hold.

I am off on Friday so I have told Mark that once approval for the letters is received, they can go Monday at the earliest which he is ok with.

14.263 Outlined below is a description of the remaining issues that emerged, which essentially prevented a letter to both GPs and patients being sent out. In the period between May-July 2017, there was significantly increased concern from patients and their representatives regarding blood patch treatments that had not been authorised. A letter explaining the position had first been mooted as far back as February 2017. The failure to agree a process and a pathway to ensure that both GPs and patients were kept informed was a significant failing. The overall impression was one of excess caution and an overabundance of concern, including a concern about naming the fact that this related to Dr Watt's patients. While one can understand that there was a legitimate issue regarding consistency of information, the process that evolved was sporadic and opaque. The situation needed to be gripped and it was not. Patients were unnecessarily kept in the dark. Further, it was not clear who was leading on the process and consequently the issue kept being deferred.

14.264 By 9th September, with numerous letters, phone calls and emails from patients and elected representatives still coming into the Trust, Mr Young wrote to Mr Watson in the Medical Director's Office:

Peter,

Good to see the formal review process ready to commence.

However, I am conscious of the fact that there still hasn't been a formal letter to GPs – this has been drafted and ready to go for some time now so it would be good to get a steer on this.

There's also the steady trickle to MLA/Constituency queries mostly blood patch related.

Thanks Frank

- 14.265 The Inquiry notes that the issue of the blood patching review, which was included in the cases sent to the RCP, was, at that stage, being raised as a further reason for having delayed writing to patients and GPs. The Inquiry does not accept that this was a valid reason for delay. On 18th September, Mr Young wrote to Mr Watson, following on from further complaints and enquiries from patients. Mr Young stated:

Peter

We have had a letter waiting to go to patient's affected GPs for some time now but that's been on hold awaiting the RCP review.

As for complaints and enquiries like this from patients, GPs or political representatives we are responding to these as and when they arrive.

I'm going to be on leave from today so have copied Gerry in to draft a response to this one.

Frank

- 14.266 Mr Atkinson followed this up indicating to Mr Watson that he had been working on revised letters to patients' GPs and the drafts were then provided to those with specific responsibility. On 20th September, Dr Craig highlighted to Dr Mitchelson concerns about clinical responsibility:

Mark

I have tweaked letter to GP. You will see I have taken out word clinical before queries as I feel it could be taken that I am in some way taking degree of responsibility for their clinical management. While I am happy to give generic advice in regards to treatment pathways etc., I am not prepared to take any personal clinical responsibility for patients I have never seen, not examined and not been able to review all their investigations.

I would also like it to be recorded, not necessarily in the letter, but instead by reply that I have the support of the Trust for not contacting patients if GPs contact me and ask me to do so, to answer any queries that patients or their families might have. Likewise, I will not be replying to direct requests from patients or their families for information. Firstly, I do not have the time to do so,

but more importantly I am not willing to undertake quasi-consultations that are not in keeping with my usual clinical practice and which I feel would fall way below an appropriate standard of care.

John

14.267 By this stage, Dr Watt was restricted in his practice and queries began to circulate as to what should be said to patients who were making enquiries. An example of this is on 15th September, the Complaints Department indicated to Mr Atkinson that she would advise a patient *“that her previous consultant had been on unexpected leave and at the time of her complaint the Trust was unsure of duration”*. Ms McKimm went on to state: *“As it became evident that consultant would be off longer than expected the Trust has sought another consultant to take up appointments”*.

14.268 On 19th September, Mr Watson forwarded revised letters to patients to both Dr Mitchelson and Dr Craig. Dr Craig approved these on 21st September and Dr Mitchelson emailed on 5th October to say that he also was happy with the wording. When the drafts were forwarded to Dr Jack on 19th October, Dr Jack highlighted that the letters were different from those that had originally been drafted. In an email of 25th October, Dr Jack emailed Mrs Owens enclosing the original draft that Dr Jack had drafted in April 2017:

Bernie

Here is the original letter that I had drafted.

Following the request for the meeting below we did meet (? In your office) and discussed if the letter had gone. I made clear that I wasn't concerned about the reference to Dr Watt. We also agreed a letter to GPs needed drafted. I was content that John signed the letter.

The letter then sent in October (enclosed) is very different to the one prepared in April, but I appreciate time has moved on. I am not clear on where this was in the system or the various iterations.

I will follow up with Peter for my own understanding.

Cathy

14.269 By 26th October, Ms Westwood was able to indicate to Mrs Owens that the drafts had finally been agreed and that, following a further review by the Medical Director and the insertion of the names from the database, the letters should be available to send out. Mr Watson, on 29th October, raised a concern about the accuracy of the reference to reviewing the records. Dr Jack referred him to Mrs Owens, and, with a minor change, it appears that blood patch letters were agreed by 1st November. Ms

Westwood confirmed that the letters to the GPs were posted on 6th November and the patient letters subsequently on 8th November.

- 14.270 The delays and confusion highlighted above continued for many weeks. While all who had some involvement periodically queried the delay, there is no sense from the contemporaneous evidence that the matter was one of extreme urgency. The Medical Director's Office also had the benefit in Mr Watson as an administrator who was assiduous and determined on following up on decisions when they had been made. The difficulty however, was that it was never clear as to who was to take responsibility to ensure that patient and GP letters were issued. The process was derailed by the slightest caveat, and it often took weeks before focus returned.
- 14.271 Patients who are anxious and concerned about a serious medical condition have the right to be given an explanation within a reasonable time. If an independent review is to be carried out, then that of itself is part of the explanation. Concerns about mentioning Dr Watt and ensuring that every patient was contacted at exactly the same time should not have been allowed to impede progress in a disproportionate manner. The Inquiry Panel does accept that the number of patients involved with Dr Watt, who had been diagnosed by him with a condition that most neurologists rarely came across, introduced a logistical problem when Dr Watt went off and also previously when Dr Peukert did not consider it appropriate to approve the vast majority of his patients for the treatment. It is for this reason, however, that the letter to patients and GPs, giving at least some explanation, was all the more critical.
- 14.272 The ongoing issue of communication with patients who had been under the care of Dr Watt continued in mid-late 2017. The general response at this stage was to emphasise the following:
- (i) That the Trust was undertaking a review of the risks and benefits of blood patch procedures. As part of the review, the Trust had asked an independent expert to review a number of cases.
 - (ii) That the review would be completed in early 2018 and that would identify any measures that needed to be put in place.
 - (iii) A patient diagnosed with a CSF leak would continue to be given, in appropriate circumstances, a blood patch procedure by a clinically competent neurologist.
 - (iv) The decision to review blood patch procedures was made in the best interests of patient safety as the procedure was not without risk.

- (v) Dr Watt was currently unavailable and would be for the foreseeable future.
- (vi) The Trust had initiated a recruitment process for locum consultant staff to cover Dr Watt's clinical commitments.

14.273 The above approach failed to take into account that Dr Peukert had already determined in a majority of instances that a blood patch was not justified. That information should have been shared with those patients.

14.274 The Inquiry Panel also notes that consultants tended to be focused on their own patients and clinical pathways. It was not until Dr Peukert's initial investigations and reviewing of patients, which commenced in January 2017, that the extent of the problem began to properly emerge. Unfortunately, however, the emphasis within the MHPS process on confidentiality meant that as few people as possible should be informed of the developments. This, in the view of the Inquiry Panel, contributed to the overall problem and made efficient management extremely difficult.

14.275 Events leading up to the restriction first imposed on 13th December 2016 have also been set out in detail in the November 2016 - May 2018 chapter. The Inquiry Panel notes the following at that time:

- (i) Although Dr Watt did not attempt to hide his clear conviction that the incidence of SIH was dramatically under-diagnosed, no one, at any level, whether nurse, registrar or consultant in the Neurology department, appear to have been overly concerned about the high incidence of blood patching. It seems to the Inquiry Panel that there are several reasons for this, which would include:
 - (a) A reticence among both registrars and nurses to question the decision-making of a consultant with regard to diagnosis.
 - (b) An incurious attitude among consultant colleagues, who were reluctant to interfere or question the overall practice of a respected and senior consultant.
 - (c) While it was an accepted feature of neurology, that consultants could often disagree about a diagnosis, this seems to have induced a less inquisitive approach, which made the discovery of aberrant practice much more difficult.
- (ii) Within days of the restriction being imposed, Dr Watt was seeking to continue with the procedure and his actions over the following months simply highlighted his conviction that the fundamental problem was one of under-diagnosis.

- (iii) It is particularly striking to note the approach of a non-neurologist, local GP, who asked what the Inquiry Panel think was an obvious question: *“Why are people undergoing blood patches when there is a lack of objective evidence to support intracranial hypotension?”* While the Inquiry Panel accepts that there may be some cases where the symptoms are such that they can point to the condition, even in the absence of imaging evidence, the picture that emerged when Dr Peukert drew up his list of patients in January 2017 was alarming. In relation to SIH, Dr Jack did not hesitate. As soon as the cases involving blood patching, where the diagnosis of SIH was not supported by imaging, etc., were brought to her attention, she immediately imposed a partial clinical restriction on whether a patient should have been diagnosed with SIH. That decisive action and the involvement of Dr Peukert, directly led to the discovery that very few of the patients who had been proposed for blood patches met the criteria for a diagnosis of SIH.
- (iv) One cannot say that evidence regarding Dr Watt’s approach to blood patching was lacking. Dr McDonnell referred to the practice as reaching *“epidemic proportions”* in December 2015. Dr McKinley had always thought of it as *“an infrequently performed and required procedure”* in November 2015. Ms Lundy, a non-neurologist, wondered why there had been *“such a need for this new procedure”* in 2015. The problem was, however, that what were often casual or reflective comments never led to a much more detailed analysis or questioning taking place.

Conclusions and Findings:

- 14.276 The evidence suggests that Dr Watt was doing an increasingly large number of blood patch procedures. The response of the Trust was focused on how these procedures could be accommodated. Essentially, the astonishing rise in such procedures reveals an organisation that did not know what was happening or where it was happening and, when problems were raised, did not properly interrogate or question obvious discrepancies. There was sufficient information available for a process of questioning why so many procedures were being carried out from at least the middle of 2015.
- 14.277 The Inquiry Panel sought to collate the available information and considered to what extent management, nursing staff, registrars and consultants were (a) aware of the problem and (b) acted on the problems that emerged. Although various attempts have been made to accurately estimate the number of blood patch procedures that were being carried out by Dr Watt, the Inquiry is satisfied that none of the figures that have been provided by the Trust are entirely accurate and, in the view of the

Inquiry Panel, the figures that have been given represent an underestimation of the prevalence of this procedure. The fact is that it will never be known how many procedures were taking place on a weekly basis and how many patients underwent more than one procedure.

- 14.278 The Inquiry Panel believes that the fundamental mistake that was made in relation to blood patching goes back to questions that were raised in July 2015 by Sister Vanessa Boyd and subsequently by Ms Lundy. Why was there no discussion/negotiation for the service? The high incidence of blood patching evolved from a situation where there were only several per year to the point where well over 100 were carried out on an annual basis. It cannot be the case that such treatment can so dramatically increase in the absence of (a) academic support; (b) a proper case being made for the service; and (c) a clear plan for implementation of the service to be in place.
- 14.279 What happened was, in fact, a form of organised chaos. Patients were meeting Dr Watt privately at HPC or UIC or within the NHS and being told to attend within days at the Royal Victoria Hospital. Hospital administration and the nursing staff struggled to cope with the informal methods being used. Ward staff were put under intense pressure to accommodate this service, even though they were concerned about general patient safety and the appropriateness of carrying out a day procedure in Ward 4E. Nobody seemed to know who was in charge and the extant governance systems were singularly unable to cope with a consultant who was determined to pursue this clinical path in respect of many patients who would not ordinarily have been offered such a treatment. Faced with a decisive and committed consultant, the system merely adapted itself and tried to absorb the increase in procedures. That occurred, even to the detriment of other more routine, but critical procedures, such as lumbar punctures.
- 14.280 As with the complaints system, the problems within Neurology were not because the information did not exist or that, for instance, treatment was carried out in a clandestine manner. Every treatment was coded and collated, or was meant to be, and detailed records should have been kept of every procedure. Whilst the Trust systems were incapable of capturing every treatment, even on the figures it did have readily at its disposal, there was plenty of information which could have been utilised to spot patterns of potentially aberrant practice.
- 14.281 The problems emerged because the prevailing culture was such that consultants were rarely questioned or challenged in their own domain. The governance system was inadequate and those in positions of clinical responsibility, who also have an

onerous clinical practice, had limited time to manage. What is more, the expectation of their colleagues was that they would not be managed by them, and there was the greatest reluctance to undermine the independence of peers.

- 14.282 At certain points, consultants who were being asked to comment on the number of procedures and the use of facilities, assumed that the significant increase in the procedure was related to associated problems with lumbar punctures that had unintended side effects. This was, for instance, the response of Dr Gavin McDonnell when he was invited to the meeting on 24th November 2015. Dr McDonnell was not able to attend that meeting but had earlier questioned the need for 90 blood patch procedures per annum. Similarly, on 29th October 2015, Dr McKinley had commented that he had thought of blood patching as an *“infrequently performed and required procedure”* within neurology.
- 14.283 If one considers the critical meeting of consultants on 24th November 2015, it is clear that the list of blood patches carried out by Dr Watt obtained by Ms Lundy from Sister Vanessa Boyd was not entirely accurate, in that it actually under-represented the number of blood patches the Inquiry now knows had taken place. It is noted that Consultant Neurologists, Dr Aidan Droogan and Dr Gavin McDonnell, did not attend; although Dr McDonnell on 30th October 2015 in an email, had queried the need for 90 blood patches per annum. For reasons that have never been explained, Dr Watt also did not attend. The Inquiry Panel regard this as remarkable. If ever there was a need for an explanation to be provided by Dr Watt, it was at this critical moment. At the meeting, Dr John McKinley had noted that this was an infrequent procedure traditionally and questioned why there had been such an increase in demand. There appears to have been a rough and ready calculation done and certain actions taken, but the outcome of the meeting served to give a false reassurance to the consultants present that there was a rationale for the rapid increase in such procedures. At the very least, Dr Watt should have been asked to explain his position to the other consultants especially given in how rarely consultants had come across such a diagnosis in their own practices.
- 14.284 It is quite clear that no red flag emerged from the meeting and ultimately the lack of curiosity or enquiry is the responsibility of management. The Clinical Director, was, in the view of the Inquiry Panel, required to question Dr Watt as to why he did not attend the meeting and what his explanation was for the dramatic increase in procedures. We now know from the review carried out by Dr Peukert, which commenced in December 2016, that a significant number of patients were due to undergo procedure which was not clinically justified.

- 14.285 Much of the focus of the nursing staff and, to some extent, the other consultants, was the fact that the neurology ward was being overburdened by the number of blood patch procedures. This was regarded as a capacity problem to be solved as opposed to giving rise to questions on why there was such a dramatic increase of procedures.
- 14.286 Ms Lundy, then Assistant Service Manager, was particularly exercised about the demand of such procedures at a time when there had been a pseudomonas outbreak in the neurology ward. She asked the correct questions without receiving any satisfactory response. The Inquiry Panel does note that when the concern about pseudomonas abated, the system seems to have reverted comfortably back to a system of doing everything one could to assist Dr Watt to carry out the blood patch procedures in the PTU or other facilities, if they were available. While problems also re-emerged because of pressure from registrars about space for lumbar punctures in the PTU, there was clearly irritation on the part of colleagues, but the focus was on ensuring that routine procedures were not interrupted rather than on more existential questions about the astonishing increase in the number of blood patch procedures being carried out by Dr Watt.
- 14.287 It was the consistent evidence of all the neurologists that appeared before the Inquiry Panel that they had come across only a handful of patients during their careers who would have required a blood patch procedure. This is borne out by the figures which record the procedures in the years prior to the dramatic rise that began in 2014.
- 14.288 The Inquiry Panel noted that the pressure on the system and the running of Ward 4E had caused several personnel to complain to the Clinical Director, Dr Craig. The Inquiry Panel recognises that a new procedure can arise, or a rare treatment can become more widely used to the point where it supplants other modes of treatment and become an accepted method. It is further understood that one Consultant Neurologist can develop a particular interest or specialism, which his colleagues do not share. In this case, Dr Watt was technically adept at carrying out a blood patch procedure. This was recognised by his colleagues, some of whom would have referred patients to him where they had suspected SIH. Nevertheless, the scale of the increase should have caused greater enquiry and curiosity amongst colleagues. The increase in the diagnosis of SIH and consequent blood patch procedures was entirely due to Dr Watt.

14.289 Dr Jamie Campbell also gave evidence on 9th January 2021, that anyone working with Dr Watt or in the neurology unit could not have been unaware of how prevalent the practice had become:

Mr Lockhart QC: What about the blood-patch testing? Do you think that that was something that was noticed by the registrars? The fact that — I mean, the fact is that Northern Ireland — Belfast, in particular — went from two to 12 per annum to anywhere from 120 to 200 a year, which was, by any stretch of the imagination, a world record kind of number being done in Belfast. We have the greatest difficulty in understanding why this was not extremely evident to everybody.

Dr Campbell: I agree entirely. It's inconceivable that anyone working with Dr Watt or in that unit would not have been aware of that; maybe not the entire extent, but —.

Mr Lockhart QC: At the very least, questions would've needed to have been asked as to why spontaneous intracranial hypotension had become such a massive problem in Northern Ireland.

Dr Campbell: Correct. That was my first thought upon returning.

14.290 It was the case that most neurologists rarely came across genuine cases of SIH. Nothing advanced as an explanation to the Inquiry Panel satisfactorily explains why no other consultant seemed to properly question the reason for such an extraordinary increase. At the critical meeting, which was called to ostensibly discuss the problems that had emerged in Ward 4E and the PTU, some consultants present expressed surprise at the number of procedures, but this does not appear to have overly influenced the meeting and the consensus view was that, as many consultants were referring cases to Dr Watt, this somehow explained the dramatic growth of the procedure. It is ironic that it was the Assistant Service Manager, Ms Lundy, who asked the critical questions, which were never adequately answered, in her email of 21st July 2015 to the Clinical Director, Dr Craig. This email arose from a similar concern being expressed by Sister Vanessa Boyd, the Nurse Manager for Ward 4E and the following questions were prescient:

- (i) Why there was no discussion/negotiation for the new service?
- (ii) How referrals were received and the waiting lists managed?
- (iii) Why there was such a need for this new procedure?
- (iv) Why radiology were not involved because of the use of glue?

- 14.291 When one compares the false reassurance that emerged from the critical November 2015 meeting with the results of Dr Peukert's review of patients, who were due to undergo such procedures in 2016, the differences are stark. In November 2015, consultants sought a way to explain the unusual incidence and patterns that were causing such pressure within Ward 4E. When Dr Peukert carried out his own review, he discovered that of the 87 patients he had reviewed, only 12 had met the criteria for a blood patch procedure. The failure to require an explanation from Dr Watt in November 2015, in the view of the Inquiry Panel, clearly contributed to the further substantial increase of such procedures in 2016. Dr Watt, far from seeing that there was any problem, maintained, even after he had been suspended from clinical practice, that this procedure needed to be further increased, not diminished. The Inquiry Panel believes that even the most basic of reviews at the time the queries were raised in 2015, would have led to the clear conclusion that many of these procedures were not clinically justified.
- 14.292 While Dr Watt may have been skilled at carrying out the actual procedure, it is noteworthy that when enquiries were made by Dr Peukert and, to some extent by Dr Craig in December 2017, the view of outside specialists was that targeted blood patch procedures are *"best performed either by anaesthetists or pain specialists"*. Arguably, therefore, Dr Watt was developing a specialism for a procedure that should not normally be carried out by a neurologist. Such procedures were also not without risk. The Inquiry Panel received evidence from some patients who suffered greatly as a result of the procedure being carried out. This does not appear to have been even considered at the time and raises questions as to the extent to which there is any meaningful degree of accountability between consultant colleagues. This issue is discussed further in the Medical Culture chapter and in relation to the benefits in working in multi-disciplinary teams.
- 14.293 It is also striking that Dr Watt presented on SIH to the Neurosciences Grand Round on 3 occasions between 2014 and 2017. The first case featured a patient who had received 4 blood patch procedures in a month. This does not seem to have been picked up on or queried by any other neurologist and the Inquiry Panel notes how few neurologists remember ever attending one of the three presentations²³. The documentary evidence clearly indicates that the presentations had taken place.
- 14.294 The Inquiry Panel takes the view that there was sufficient evidence prior to December 2016 to, at the very least, cause much more significant questions to be asked. The system in place of medical management, when combined with the medical

²³ See Appendix 1.

management system in place, militated against the kind of robust questioning that would have been needed. The fact that Dr Watt did not even attend the consultants' meetings when these issues were discussed should have been a cause for concern. It was not, because the focus of his colleagues was to try and ensure that other, what some might term routine, procedures, such as lumbar punctures, were not being interrupted. At the same time, the focus of the then Assistant Service Manager was understandably in containing a pseudomonas outbreak and preventing the risk of infection. Ms Lundy did ask the essential questions, but they were never answered properly because the focus was elsewhere. A system that is working well and a culture which is focused primarily on patient safety should ensure that such a dramatic increase in a rarely used procedure is the subject of much more intense scrutiny. That did not happen with regard to blood patching.

- 14.295 The Inquiry has gained a considerable insight into Dr Watt's thinking from the draft Verita report and the discussion of the blood patch issue between Dr Clough and Dr Watt as set out in paragraphs [67]-[71] above. Dr Watt clearly decided at a certain point that there were numerous patients who may have a problem with SIH in a situation where there was no imaging evidence. As he stated, the procedure became a form of diagnostic tool and he felt that about half the patients treated were assisted. The problem was, however, that Dr Watt had stepped outside the published guidelines and was acting without consulting his colleagues or with the sort of academic and scientific rigour that should accompany a development in treatment.
- 14.296 Events surrounding the partial restriction imposed by Dr Jack in December 2016 are set out in detail in the November 2016 - May 2018 chapter. Some of the difficulties in the interpretation of that restriction are set out above. On reflection, the primary problem that emerged was a lack of clarity about who was responsible. Was it the Clinical Director, who had been asked by the Medical Director not to be a part of the internal report prepared by Dr Gray and Dr McConville because he had personally raised one of the index cases? Was it Mr Watson on behalf of the Medical Director? Mr Watson's actions were conscientious, but one did not get the impression that he was directing, merely reminding and cajoling. He believed that the actions to be taken were the responsibility for those within the Neurosciences Division. Mr Young, as the Co-Director would have had an overall management role in Neurosciences, but there is little evidence that he realised that he should be overseeing the process. The same applied to Mrs Owens who had only a peripheral role. Clearly the imposition of a restriction was a matter for the Medical Director, but the issues around the booking in of patients, obtaining of medical notes and records, recording procedures,

writing to patients and interpreting the partial restriction (and identifying where it was still engaged) were characterised by a lack of clear oversight and management. It is still not clear to the Inquiry Panel as to who was ultimately in charge. This was a failure of both governance and management.

14.297 If some allowance is made for colleagues' assumption prior to November 2016 that the number of blood patch procedures was simply a new treatment that Dr Watt had been interested in, then the situation changed unalterably in January-February 2017 when Dr Peukert produced his spreadsheet. If one was proceeding on the basis that tests were a prerequisite to diagnosis and most instances of the condition would reveal imaging evidence, then the conclusions of Dr Peukert were shocking. It is at this point that alarm bells should have been sounding. There is a range of factors, which, if they had been reflected upon in any manner, would have led to further investigation. The Inquiry Panel highlights the following:

- The dramatic increase in procedures.
- The fact that the increase in procedures was having a significant impact on the use of facilities.
- The guidelines²⁴ in relation to SIH and where and how the procedure should be performed.
- Dr Watt does not appear to have been directly asked any questions by other consultants.
- Dr Watt did not attend any of the consultant meetings called to discuss the number of procedures. This non-attendance does not appear to have been regarded as unusual nor were efforts made to either arrange the meeting so he could attend or speak to him about the issues arising subsequent to the meeting.
- Dr Watt was clearly a strong advocate for the use of this kind of procedure.
- Dr Watt was in no way reticent either to discuss or carry out blood patch procedures, before and after the partial restriction in December 2016.
- Concerted efforts were made by Dr Watt following the imposition of restrictions in 2016 to have other neurologists recommend treatment by a blood patch procedure.
- Dr Hunt's evidence is particularly relevant when, in March 2017, he approached the Co-Director Mr Young regarding a procedure, which he

²⁴ The Guidelines referred to in the Verita Report and the papers written by Dr Schievink are not the same as formal RCP Guidelines but nevertheless neurologists recognised that there were guidelines based on the medical literature which should be followed in the diagnosis of SIH and decision to administer a blood patch. This would have highlighted inter alia the importance of abnormal imaging.

had been asked to recommend and which he felt was not appropriate. This interaction took place at or about the same time that Dr Peukert's spreadsheet was compiled.

- Dr Peukert's review in December 2016-February 2017 revealed that of 87 proposed procedures, only 12, were justified. That should have been a further red flag to those in clinical governance. The reaction, however, by the Clinical Director and the Co-Director was underwhelming and cautious. The fact that Dr Peukert's review should have been immediately brought to the attention of the Medical Director.
- The Inquiry Panel has found little reassurance in the evidence adduced, that subsequent dramatic increases of a particular procedure will now be questioned and scrutinised more carefully. The assumption amongst consultant colleagues appears to be that if neurologists change their practice significantly, there must be a valid clinical reason, which does not seem to require scrutiny by their peers.

14.298 The effect of the above is cumulative. If the management should already have been alert to what was an extraordinary increase in the number of procedures to treat a rarely found diagnosis of SIH, then that concern should have intensified following the evidence prepared by Dr Peukert in his spreadsheet. Unfortunately, the evidence suggests that it was still some months before there was a proper realisation of how aberrant the practice had become.

14.299 If the situation with regard to consultant knowledge changed fundamentally once Dr Peukert began to compile his spreadsheet, the Inquiry Panel has carefully reflected on the actions taken by those with responsibility post January/February 2017. While it is recognised that complete restriction was imposed effectively at the end of June 2017, there remained a period of 5 months where Dr Watt continued to advocate the procedure in a large number of cases, despite the fact that the evidence obtained revealed only a limited number of cases where the diagnosis and treatment was justified.²⁵

14.300 The following factors emerged with sufficient clarity during this period (January – June 2017) to raise the question as to whether earlier action should have been taken:

- (i) Dr Watt's complete determination to continue with the treatment and especially his efforts to circumvent the partial restriction.
- (ii) The growing evidence of the number of blood patches that (a) had been carried out; (b) were being repeated on numerous occasions; and (c) were

²⁵ The fact that Dr Watt advocated such a procedure did not mean that it was carried out.

outstanding and the significance of the number of procedures eclipsing the earlier approximate calculations of consultants.

- (iii) The concerns of Dr Hunt that the patients referred to him by Dr Watt did not, in his view, fulfil the criteria for a diagnosis of SIH.
- (iv) The fact that Dr Hunt was sufficiently concerned to raise the matter with senior management.

14.301 The question having been raised the Inquiry Panel noted the following impediments to effective action which emerged:

- (i) The failure primarily of Mr Young, but to a lesser extent Dr Mitchelson and Dr Craig to escalate the concerns raised by Dr Hunt to the Medical Director.
- (ii) Assurances given that the restriction was being complied with, when even basic investigation would have revealed further ambiguity, which was being utilised by Dr Watt. For example, colleagues may have been referring a patient to Dr Watt for an opinion on whether the condition of SIH was the presenting problem, not to necessarily carry out a blood patch procedure. These referrals were deemed to be authority for the procedure and any repeat treatment, which obviated the need for Dr Peukert to review.
- (iii) The restriction was often misinterpreted so that extensive efforts were made by staff to identify any referral from another neurologist or neurosurgeon, regardless of when or why the referral was made. Where that was identified the assumption was made that Dr Peukert's approval was not required.'
- (iv) Few consultant colleagues, including most obviously the Clinical Lead, Dr McDonnell, were aware of the restrictions from their inception. The desire for discretion and confidentiality because of the perceived requirements of the MHPS procedure, permitted the situation to develop in a manner which was, at the very least, against the spirit of the partial restriction.

14.302 It has been accepted elsewhere in the report that the pressure on neurology services is such that clinicians who are also involved in clinical management would need much greater time devoted to their management responsibilities. It is neither practical nor fair to expect excellence in clinical management when the clinicians in the role and more especially the Clinical Director and Clinical Lead are required to fulfil all their duties on 8 hours and 2 hours per week respectively. The Panel recognises that the overall system benefits from clinical management being deputed to experienced clinicians, but the question of balancing clinical duties with clinical management

has not been resolved. While it is the case that there is an additional layer of management within the Service Team, the obvious reticence of non-neurologists to challenge what they perceive to be a clinical matter is apparent. The result, however, is that large gaps appear in the management system, which can potentially affect overall patient safety.

- 14.303 The Inquiry Panel is of the view that had Dr Jack been aware of a breach of the restriction as relayed by Dr Hunt at the end of March 2017, she would have immediately acted to impose a complete restriction on Dr Watt carrying out the blood patch procedure. The Inquiry Panel believes, however, that the numbers alone identified by Dr Peukert, if properly interrogated and analysed at an early stage, may have been sufficient evidence of itself to justify a complete restriction. The Inquiry Panel notes that it was concerns about other areas of his practice, and not blood patching, which resulted in a complete restriction being applied by Dr Jack.
- 14.304 Although the importance of communicating with patients who were expecting a blood patch treatment was highlighted as far back as February 2017, the delay in issuing a letter to both GPs and patients affected was a serious omission. The contemporaneous documentation suggests that when the slightest issue was raised about communication, it initiated further delay and a loss of momentum. Nowhere in the documentation does it appear that one person was tasked with the responsibility to ensure that a letter was sent out timeously. In addition, subordinate issues, such as whether Dr Watt would be named in the letter, were given an unnecessary prominence in discussions. The focus must always be on patient safety and ensuring that patients are properly communicated with to relieve their anxiety and distress. The delay in this case of nearly 10 months was unacceptable and none of the explanations, which appear both contemporaneously and in the oral evidence given to the Inquiry Panel, adequately excuse such a failure.

Consultants - Attendance at Neuroscience/Blood Patch Presentations

Doctor	2014	2016	2017
John McConville	No record; no recollection	DNA	Attended; no recollection; no notes
Colette Donaghy	No record; no recollection	No record; no recollection	Attended; asked questions re sufficiency of info re. SIH.
John McKinley	DNA	Attended one or both. No records. Recalls reference to 'glue'. Believed MDT involvement (Probably 2016).	
Stella Hughes	Presented	No records. Neither confirm nor deny	No records. Neither confirm nor deny
Thomas Peukert	DNA	Not in attendance for presentation	DNA
Tom Esmonde	DNA	DNA	Attended; brief note - SIH in Marfan's
Mark McCarron	No recollection; brief note re 4 EBPs	DNA	DNA
John Craig	No record; no recollection	No record; no recollection	DNA
Stanley Hawkins	Believes he attended	DNA	No record; believes DNA
Seamus Kearney	No record. Neither confirm or deny	No record. Neither confirm or deny	No record; believes he attended. No concerns.
Jamie Campbell	DNA	No record; believes he attended. Nothing exceptional recalled.	DNA
Raeburn Forbes	DNA	DNA	Attended meeting but not presentation
Karen McKnight	DNA	DNA	Attended; no recollection
Ferghal McVerry	No record; no recollection	No record; no recollection	No record; no recollection
Orla Gray	Attended	DNA	DNA
Gavin McDonnell	No record; no recollection	No record; no recollection	No record; no recollection
Ailsa Fulton	DNA	DNA	DNA
Ellen Campbell	No record; believes attended	Attended	DNA

Doctor	2014	2016	2017
Aidan Droogan	No record; believes attended	Attended; brief note - recalls 'glue'. No recollection of controversy	DNA
Karen Doherty	DNA	No record; no recollection	Attended. Brief note - SIH in Marfan's
Paul McMonagle	Attended. Notes ref Schierink criteria; imaging to ID leak site; most patients needing 2+ EPBs. No recollection.	Attended. Notes SIH evidence 5/100,00 f/a. No recollection.	Attended. Brief note re KM
Stephen Cooke	DNA	DNA	DNA
Stephen Haffey	DNA	DNA	Attended meeting; no record or recollection of Watt presentation - may have left early.

Registrars - Attendance at Neuroscience/Blood Patch Presentations

Doctor	2014	2016	2017
Stephen Barr	DNA	DNA	Attended; no recollection of C7/TI blood patch but remembers case. May have left early.
Laura Best	DNA	No record; no recollection	No record; no recollection
Jon McKee	DNA	DNA	No record; no recollection
Michael Kinney	No record; believes DNA	DNA	No record; believes attended
Ingrid Hoeritzauer	DNA	DNA	DNA
Aisling Carr	DNA	DNA	DNA
Rachael Kee	DNA	No record; no recollection	DNA
Martin Harley	DNA	No record; no recollection	No record; no recollection
Marie-Louise Kane	No record; no recollection	Believes DNA	DNA
Catherine Donaldson	Attended. Notes record presentation	No record; no recollection	Attended. Notes record presentation
Fiona Kennedy	DNA	DNA	No record; no recollection

The Inquiry received documentation from the Belfast Health and Social Care Trust (“the Trust”), other organisations and witnesses on an ongoing basis since its inception. Having read and heard the evidence of patients, clinicians and other Trust staff, it was apparent that understanding the increase in blood patch procedures would require access to all potentially relevant emails. The Inquiry requested that the Trust carry out a search of its server to identify all emails containing any key words including “*epidural blood patch*”, “*blood patching*”, “*EBP*”, and/or combinations of these words. In June 2020, the Inquiry received approximately 30,000 such emails.

The Inquiry reviewed all those emails. These included records relevant to the booking, recording and coding of blood patch procedures as well as email exchanges between doctors, Neurology staff and other hospital staff; records of PTU outcomes; and texts of clinic letters.

Several attempts have been made by the Trust to identify all the blood patch procedures relating to Neurosciences carried out in the years preceding the creation of the Inquiry. Two of those blood patch trawls have resulted in the compiling of lists of procedures undertaken, which have been disclosed to the Inquiry.

Using the sources available through the disclosure of other Trust documents, in particular the 30,000 emails referred to above, the Inquiry sought to independently identify blood patch procedures undertaken between January 2011 and June 2017 by Dr Watt. For these purposes, the procedures identified in the lists collated by the Trust have been disregarded.

For reasons which are expanded upon in this chapter, the Inquiry Panel has concluded that it will never be possible to definitively identify all blood patch procedures undertaken by Dr Watt. In assessing the records to determine whether any given procedure took place, and thereby reaching a total number of procedures for the purposes of the Inquiry’s assessment, the Inquiry Panel made the following determinations:

- (i) Where there was evidence that a ‘slot’ for a procedure was booked by Dr Watt’s secretary in the PTU, but the Inquiry was unable to identify the patient being allocated that slot by name or Health & Care Number, this was not counted as a procedure. The Inquiry identified at least seven such examples.
- (ii) One email exchange between Neurology staff demonstrated that staff believed Dr Watt to have carried out two blood patch procedures that day but were unable to identify the patients. These were not counted as procedures.

- (iii) Where Dr Watt advised in a clinic letter that he had arranged for a patient to attend for a blood patch procedure, but the Inquiry did not identify any other evidence to corroborate the procedure having taken place, these were not counted as procedures.
- (iv) The Inquiry has seen evidence that patients were at times admitted to the Neurology ward, Ward 4E, for what is described as “*a series*” of blood patch procedures, or similar language. Where the Inquiry found only evidence of admission for blood patching, but no specific number identified, this was counted as one procedure. Where there was a reference to multiple procedures, but no specific number identified, this was counted as two procedures.
- (v) In one email from Dr Watt’s secretary to a colleague, Dr Watt’s secretary listed patients whom she recalled having undergone arranged procedures. The Inquiry was not able to identify other evidence of the procedure being booked or having taken place for one of these patients, and this was not counted as a procedure.
- (vi) Mr Philip Frizzell, Superintendent Radiographer, gave evidence to the Inquiry Panel that he had identified 3 occasions on which he was able to confirm that a patient had undergone an image guided blood patch procedure, which was mistakenly recorded as a “*myelogram*”. The Inquiry also discovered patients who were recorded as undergoing myelograms and who had previously undergone blood patch procedures. No adjustment has been made to the total number of procedures to account for potential miscoding of an image guided blood patch as a myelogram.
- (vii) The audit of the code A.52.3 by the Coding Department carried out in April 2017 identified blood patch procedures associated with Dr Watt for which the Inquiry has not seen additional evidence. For these purposes, those additional procedures have not been counted towards the total.
- (viii) The Inquiry came across instances where a clinic letter or email correspondence from a treating doctor referred to a patient having had one or more blood patch procedures, for which the Inquiry did not have further corroborating evidence, such as an email between staff arranging the procedure. These were counted as procedures. For example, correspondence to a patient’s GP sent in December 2013 referred to the patient having had four blood patch procedures over the previous month. Where staff express uncertainty about whether a procedure went ahead, this has not been counted as a procedure.
- (ix) In a small number of cases the Inquiry observed “*outcome*” records for procedures carried out in the PTU for which there was no further evidence, such as an email booking in the procedure. In view of the evidence given by Trust staff that Dr Watt

on occasion would arrive at the PTU with a patient to carry out a procedure without having arranged it in advance, the Inquiry found that these procedures did take place. This was further corroborated by evidence obtained by the Inquiry which indicated that one of those patients was treated by Dr Watt at around the same time as the outcome record stated. These instances were counted as procedures for these purposes.

- (x) On occasion, Dr Watt's secretary sent emails to book/hold slots for blood patches. Normally these emails were followed by further emails providing patient details for those who were to be booked into those slots. In some instances, however, the Inquiry did not see such follow-up emails with patient details. Where this has occurred, the slot has still been noted on the INI EBP²⁶ Table.
- (xi) On two occasions, patients were booked in, and reference numbers were provided. The Inquiry was unable to match these numbers to patient names using material disclosed to the Inquiry and, as such, was unable to identify the patient(s). These procedures have, nevertheless, been recorded in the INI EBP table. It is, therefore, unclear whether these 2 entries relate to one or 2 patients. Adopting a conservative approach to totalling, just 1 patient has been counted against these entries.
- (xii) In several instances, patients who are known to have received multiple blood patches appeared on neuroradiology lists for myelograms/CSF scintigraphy procedures. On the available information, it was not possible to rule out that some of these procedures may have, in fact, been image-guided blood patches. Where patients have appeared on lists for these procedures, these have been captured in the INI EBP table, but they have been discounted for the purposes of calculating total procedures. However, the potential for the true total to be higher ought to be noted.
- (xiii) The Inquiry has more than sufficient information to find that procedures were not always accurately recorded. For instance, the epidural blood patch of INI 336 was captured for the first time on a lumbar puncture audit and this at least raised a question as to whether some blood patches may have been erroneously recorded as lumbar punctures.
- (xiv) On several occasions, patients received blood patches as in-patients (usually on Ward 4E). Many of those patients who were admitted as inpatients appear to have had multiple blood patches (described as a "series"). Where this has occurred, the total number of procedures performed is not captured in the data provided by the

²⁶ Independent Neurology Inquiry Epidural Blood Patch Table.

Trust. As such, total procedures for those treated as in-patients may be higher than indicated.

- (xv) The Inquiry received examples of cases, where letters/emails to GPs disclosed previous blood patches, which were not captured in the Trust data. Where this has occurred, references to previous blood patches by the treating consultant have been added to the total number of blood patches counted by the Inquiry.
- (xvi) The Inquiry noted examples of both PTU²⁷ outcomes (i.e., records of procedures) for patients who have not received blood patches/have had their procedures cancelled, e.g. on one occasion INI 486 was scheduled for an EBP, only to be replaced by INI 485. The Trust has provided PTU outcomes for both INI 486 and INI 485 on this date (albeit it appears that only INI 485 underwent the procedure).
- (xvii) In other cases, the Inquiry did not see PTU outcomes for patients who have undergone blood patches (e.g., INI 487 – emails confirm that the PAS record was wrong, and she did have the procedure).
- (xviii) In one other case, the Inquiry obtained a PTU outcome for INI 488 with no other record of INI 488 being booked in. INI 488 appears to be an independent sector referral. The precise mechanism of referral is unclear.
- (xix) The Inquiry was also given numerous examples of cases where Dr Watt has performed blood patches on patients under the care of other consultants. We have also seen at least one referral (from Dr Raeburn Forbes).
- (xx) The EBP emails show EBPs being performed in the following locations: Ward 4E, Ward 2F, Ward 4F, PTU (Programmed Treatment Unit) and DSU (Day of Surgery Unit – sometimes also recorded as ‘IR’ for interventional radiology).
- (xxi) It appears that Dr Watt initially consulted with INI 489 when he was under 14. INI 489 went on to undergo 2 blood patches (aged 15 and 16, respectively).
- (xxii) The figures in the table below are adjusted to discount queries. In circumstances where a patient was admitted to the ward for a series of blood patches, only one procedure has been recorded against that patient on that occasion.

²⁷ Programmed Treatment Unit

Patient name	Date	Considered by Peukert?	Peukert outcome?	In Trust '15'?	Within restriction?
INI 457	03.01.17	No	N/A	Yes ²⁸	Yes
INI 458	03.01.17	Yes	Approved	Not known	Not known
INI 459	16.01.17	No	N/A	Not known	Not known
INI 460	16.01.17	Yes	Approved	Not known	Not known
INI 461	23.01.17	Yes	Approved	Not known	Not known
INI 462	23.01.17	No	N/A	Not known	Not known
INI 463	23.01.17	No	N/A	Not known	Not known
INI 132	06.02.17	Yes	Approved	Not known	Not known
INI 464	07.03.17	Yes	Approved	Not known	Yes
INI 117	13.02.17	No	N/A	Not known	Debatable: not on JC analysis
INI 266	23.02.17	Yes	Approved	Not known	Not known
INI 465	20.02.17	Yes	Approved	Not known	Not known
INI 466	27.02.17	No	N/A	Not known	Yes
INI 117	02.03.17	No	N/A	Not known	As for previous EBP
INI 467	13.03.17	Yes	Approved	Not known	Not known
INI 167	20.03.17	Yes	Approved (after a change of decision)	Not known	Yes
INI 176	27.03.17	Yes	Approved	Not known	Not known
INI 468 ²⁹	13.04.17	No	N/A	Not known	Yes
INI 470	13.04.17	Yes	Approved	No	Yes
INI 469	Unknown date prior to 5th April	Yes	Approved	No ³⁰	Not known
INI 467	08.05.17	No (repeat)	N/A	Not known	Not known
INI 377	08.05.17	Yes	Approved	Not known	Not known
INI 399	15.05.17	Yes	Approved	Not known	No (not SIH)
INI 471	15.05.17	No	N/A	Not known	No (requested to do EBP by Dr McConville)
INI 472	09.06.17	No	N/A	Not known	Not known
INI 117	15.06.17	No	N/A	Not known	Debatable: on INI analysis, yes ³¹

28 Given that we do not have a list of those patients believed by the Trust to have undergone a blood patch procedure during the course of the restriction, for the majority of these procedures we are unable to say whether or not the Trust has counted them in the total of 15 given by Dr Jack. However, we are familiar with this patient's case further to Dr Hunt's evidence. She had not had a blood patch procedure prior to consultation with him and therefore, given her inclusion in the Trust's total statistics, we have assumed the Trust have accurately recorded the date and is therefore aware that her procedure was performed under the restriction.

29 This is the only patient the Trust have identified as requiring but not obtaining Dr Peukert's approval for the procedure. We believe (and the Coding Audit records) that this patient had undergone 4 blood patch procedures in 2016 prior to this one.

30 There is no record of this patient at all in the Trust's total statistics, and therefore we have assumed that the Trust is not aware that her procedure was performed under the restriction.

31 It is noteworthy that in the Review of CT Guided Epidural Blood Patches, the Trust consider that at least one of the procedures performed on this patient required Dr Peukert's approval. The Review records that Dr Peukert reviewed this case before the procedure. In the spreadsheet records of his review provided by the Trust to INI, there is no reference to this patient.

CHAPTER 15 – NOVEMBER 2016 - MAY 2018

- 15.1 Part A of the Terms of Reference of the Independent Neurology Inquiry requires the Panel to *“evaluate the corporate governance (with particular reference to clinical governance) procedures and arrangements within the Belfast Trust, in relation to the circumstances, which led to the recall of patients in May 2018 for the period from November 2016 until May 2018”*. The Terms of Reference make clear that this specifically includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety *“within and between the Belfast Trust, the HSC Board and Public Health Agency, the Department and any other areas, which directly bear on patient care and safety and the general public, including an assessment of the role of the Board of the Belfast Trust”*.
- 15.2 This chapter of the report addresses Part A of the Terms of Reference and is set out in various stages. The evidence will first consider the period between November 2016 and July 2017. The Terms of Reference highlight November 2016 because, at that time, the Medical Director’s Office was contacted by a Comber GP, and the train of events that ultimately led to the patient recall commenced. In July 2017, Dr Watt was fully clinically restricted. Findings are made in relation to the Trust for that specific period. The report then considers the period between July 2017 and April 2018, when the review, which was carried out by the Royal College of Physicians was made available to the Trust. Findings are also made in respect of that discrete period and the report then considers, in summary form, the entire period between November 2016 and April 2018.
- 15.3 The Inquiry Panel further reflects on the separate question regarding communication and escalation of potential concerns between the Belfast Trust, the HSC Board, Public Health Agency and the Department together with any other relevant area, which bears on patient care and safety. Findings are also made in respect of this issue.
- 15.4 Finally, recommendations are made in respect of Part A of the Terms of Reference.

EVIDENCE: NOVEMBER 2016 - JULY 2017

- 15.5 The Inquiry Panel considers it necessary to rehearse the events that led up to July 2017 in detail to properly evaluate what they disclose about the issues we are tasked to address in Part A of the Terms of Reference.

17th November 2016:

- 15.6 On 17th November, Dr Colin Fitzpatrick, a GP in Comber, who also worked as an NCAS¹ representative in Northern Ireland, contacted Mr Peter Watson, the Senior Manager in the Medical Director's Office in the Belfast Trust and specifically raised a concern regarding three of his patients, two of whom had been diagnosed with multiple sclerosis and a third patient. All 3 patients had been seen by Dr Watt for neurology treatment in the independent sector before receiving treatment on the NHS from Dr Watt, in his role as a consultant neurologist within the Belfast Trust. Mr Watson immediately contacted Dr John Craig, the Clinical Director of Neurosciences within the Belfast Trust, and Dr Fitzpatrick agreed to contact Dr Craig as soon as possible. Advice was also taken from Dr Grainne Lynn of NCAS.²

20th November 2016:

- 15.7 In oral evidence on 13th May 2019, Dr Fitzpatrick indicated to the Inquiry Panel that he was somewhat apprehensive about discussing the matter with Dr Craig. To reassure himself that he was not misguided in his concern, Dr Fitzpatrick contacted Dr Orla Gray on 20th November and sent her a summary of the case histories. At the time of this interaction Dr Gray was a consultant neurologist employed by the South-Eastern Health and Social Care Trust. Dr Gray subsequently phoned Dr Fitzpatrick and raised a concern about one of the two MS cases. Dr Gray gave evidence to the Inquiry Panel that she did not know at this stage that the consultant in question was Dr Watt, nor did Dr Fitzpatrick identify the neurologist in question. Dr Gray did tell the Inquiry Panel that she had never before been phoned by a GP about the practice of another neurologist. She explained, however, that she had been reassured by Dr Fitzpatrick that he would take the matter forward.
- 15.8 In her evidence to the Inquiry Panel on 21st October 2020, Dr Cathy Jack felt that it was incumbent on Dr Fitzpatrick to point out to the Medical Director's Office that an MS specialist had also confirmed his concerns. The Inquiry Panel does not accept that there can be any criticism of Dr Fitzpatrick in this regard. It was reasonable for Dr Fitzpatrick to reassure himself before escalating the matter. The concern was brought to the proper authority, and it was thereafter incumbent on the Medical Director to make the necessary enquiries. The MS cases could have been discussed

1 **Practitioner Performance Advice** (formerly the National Clinical Assessment Service, NCAS) was established in 2001 and is now a service delivered by NHS Resolution under the common purpose, to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care <https://resolution.nhs.uk/services/practitioner-performance-advice>.

2 National Clinical Assessment Service now known as Practitioner Performance Advice.

with an MS specialist, while also recognising that the matter would need to go through a formal process. Further, the fact that Dr Fitzpatrick was apprehensive about raising the concern, is indicative of a medical culture, where the gravity of raising a concern is brought home to the person who has made the decision to escalate.

- 15.9 Dr Fitzpatrick, as the NCAS representative, would have known better than most general practitioners how to raise a concern and yet he was clearly nervous about the process. His experience can be compared with the late Dr Paul Conn who tried to raise several cases in or about 2012-2013 but was apprehensive enough about escalating his concerns that he wished to have the reassurance that there were similar cases involving Dr Watt that had been previously raised. No such information being provided, he decided to maintain patient anonymity and was wrongly told that the matter could not be progressed. This is explained in more detail in the Concerns chapter.

22nd/23rd November 2016:

- 15.10 Reassured by Dr Gray's observation on the note of the case histories, Dr Fitzpatrick contacted Dr Craig on 22nd November, requesting that Dr Craig call him. By this stage, Dr Craig had been made aware by Peter Watson that he would be contacted by Dr Fitzpatrick. In his evidence to the Inquiry Panel on 6th February 2020, Dr Craig stated: *"I was very surprised to be phoned by a GP with details of 3 cases"*. Dr Craig arranged to speak to Dr Fitzpatrick the following afternoon. In the interim, Dr Fitzpatrick emailed Dr Craig on 23rd November at 09:47 enclosing the case histories he had prepared in relation to the three patients. The case histories in relation to MS were the same as those given to Dr Gray on 20th November.
- 15.11 The matter was discussed by Dr Fitzpatrick and Dr Craig when Dr Craig phoned Dr Fitzpatrick at about 5pm on 23rd November. Dr Fitzpatrick's impression was that his enquiries were not welcomed with open arms, but Dr Craig explained to the Inquiry Panel that he was calling from a car park, which was dark and, further, that he was simply getting some preliminary details and organising the next steps.

24th November 2016:

- 15.12 On 24th November, Dr Craig informed Mr Watson that he had spoken with Dr Fitzpatrick and that they needed to meet to discuss the issues. Dr Craig was not available until the morning of 29th November.

- 15.13 Mr Watson immediately responded to Dr Craig (copying the email to Dr Jack Mrs Owens, Mr Young, and Dr Maria O’Kane) on 24th November as follows:

John,

I am available next Tuesday morning and could also arrange to be available at other times which suit you (in or out of office hours).

We will also need to involve a senior medic in discussions, and I am copying to Cathy [Jack] in the absence of an AMD [Associate Medical Director] so we can agree who should be involved in our discussion. It may also be prudent to involve Frank [Young] /Bernie [Owens] in the discussion and hence I am also copying to them.

Thanks

Peter

1st December 2016:

- 15.14 There was further email communication between Mr Watson, Dr Craig and Mr Young and a meeting eventually took place on 1st December involving Mr Frank Young³ (Co-Director of Unscheduled & Acute Care, Allied Health Professions, Imaging and Neurosciences), Mr Watson and Dr Craig. It was decided at that meeting not to involve the Clinical Lead for Neurology, Dr Gavin McDonnell, because of his previous involvement with one of the cases of concern involving multiple sclerosis raised by Dr Fitzpatrick. The Inquiry is not clear as to who made the decision or whose decision it was to make. The patient had been seen by Dr McDonnell when an NHS patient, subsequent to treatment provided by Dr Watt. Following the taking of a history and full examination, Dr McDonnell had requested tests. Dr McDonnell concluded that: *“there is really no supportive evidence for a diagnosis of MS”*.
- 15.15 In his evidence to the Inquiry Panel on 16th May 2019, Mr Young commenting on the emergence of the 3 cases, stated:

It’s something that we didn’t want to be jumping into because we have a – no disrespect to Dr Fitzpatrick but, if a GP’s saying, ‘I’ve got concerns’, we wanted to make sure that – maybe Michael was doing the right thing, maybe it was appropriate and, ‘Had Dr Fitzpatrick got the wrong end of the stick?’ Again, a senior consultant: if you’re actually going to be investigating someone, you want to be sure of your facts.”

3 Co-Director of Unscheduled & Acute Care.

15.16 The Inquiry was provided with an annotated copy of a document including the case histories as given by Dr Fitzpatrick. These handwritten annotations were made by Mr Watson and Dr Craig at the meeting on 29th November 2019. Dr Craig, when giving evidence to the Inquiry Panel on 5th November 2020, was able to also note that one of his annotations (a question mark and a delta sign) at the top of the same document made it clear to him that he was querying the diagnosis made by Dr Watt. It was decided at that meeting on 29th November to obtain a report from another neurologist with a specialty in MS as well as seeking the views of Dr Craig.

15.17 Mr Watson had detailed notes of the meeting, and the Inquiry believes that he was best placed to recall the detail of what transpired. In his second witness statement to the Inquiry of 2nd November 2021 Mr Watson stated:

... at the meeting on 1 December 2016 we discussed the issues and the steps that needed to be taken in respect of the concerns raised by Dr Fitzpatrick. I am content that my handwritten note reflects the fact that I asked Dr Craig what is, for me, a standard question in these circumstances; whether he had any immediate concerns in respect of patient safety arising from the issues Dr Fitzpatrick had raised. I have to ask that question to the likes of a Clinical Director because I am not medically qualified in order to answer it myself. I cannot now remember the precise words used at the meeting, but the message Dr Craig conveyed to me from the words used was that Dr Craig did not have immediate concerns such that restrictions were immediately necessary. I can see the words “NO IMMEDIATE” in my contemporaneous handwritten notes. In light of the assurance that was given, the course that we discussed and agreed at the meeting, subject to Dr Jack being content, was to commence preliminary enquiries through having consultant neurologists carry out case note reviews of the case.

15.18 The question arises at this stage as to whether there was sufficient evidence for the Medical Director to restrict Dr Watt in respect of his multiple sclerosis practice. The Panel noted that Dr McDonnell had already reviewed one of the patients coincidentally and had changed the diagnosis some weeks earlier. In her evidence of 5th February 2020, Dr Jack stated:

Mr Lockhart QC: Why would Gavin [McDonnell] not be able to be involved.

Dr Jack: Because he had changed the diagnosis in case X, so he already had a biased view. That is what we could have been challenged with by the doctor.

Mr Lockhart QC: Right. In terms of getting even an initial desk top view?

Dr Jack: John Craig gave that initial desk top view. You can ask me why did he not flag it and whether he didn't have the notes or whatever, but that would need to be asked ...

... Okay. So Gavin, [McDonnell] there is a patient that has the diagnosis changed. There is a consultant with a specialist who doesn't raise a flag at the time and then I have a Clinical Director who looks at it and doesn't think there is any issue of concern. He also looks at the other two. Hugo, if I believed there was any issue about patients coming to harm I would have acted. In John Craig's defence when he saw an epidural blood patch he didn't waste any time. He came straight to me and we took action.

15.19 Dr Craig was asked about his view at that time. In his evidence of 6th February 2020, he stated:

Mr Lockhart QC: Did you think you could deal with it, or did you think you needed to get the view of another neurologist.

Dr Craig: I thought I needed another neurologist because two of the cases were about multiple sclerosis, and there's just no way I could; I could formulate an opinion around the process and the investigations and the journey that the patient had had but I didn't think it would really stand up. A general neurologist who specialises in epilepsy, which was the other case, would really -- plus the fact I think these things are probably better done with more than one opinion. We saw that later on and we could argue it the other way around when we saw the opinions of John McConville and Orla Gray where there were lots of discussions around the cases about, 'What are you actually saying here?' in terms of 'Is there an issue?' 'Is there not an issue?' I think because it was multiple sclerosis, I immediately felt a wee bit out of my depth because I would have some patients with MS, but very few.

Mr Lockhart QC: What was your level of concern personally at that stage in relation to Michael Watt? By that stage you had HIG, you had immunoglobulin, you had a series of complaints, you'd had appraisal problems, you'd had [the 3 concerns raised by 3 consultants at the Northern Health and Social relating to] Care Trust [INI 286]. Was it a surprise to you it was Michael or were you going 'the rest of the data didn't hugely influence my approach'?

Dr Craig: I think I maybe said the last time I was here that certainly coming into and going through 2016, there clearly had been things that had happened in terms of the Northern Trust case and in the meeting that myself and Frank Young had had with them. This was all kind of following on quite closely. None of those things in themselves I thought identified a trigger that I had to say 'We need to stop and take stock here'. I suppose I was surprised at the level that a GP had come with three concerns because that hadn't happened before. But, as I say -- and maybe this is looking back now -- there was something about 2016 on that there was a kind of head of steam seemed to be building. Some of that was around process. Some of it had to have been about clinical diagnosis and treatment in terms of the Northern Trust case. Apart from that, I'm trying to

think, I don't think it was about specific cases that I was aware of details where there were concerns about diagnostic, diagnosis or management.

- 15.20 The issue of whether Dr Watt should have been restricted in terms of multiple sclerosis greatly exercised Dr Jack, as she reflected in her evidence. The Inquiry Panel is of the view that with regulatory responsibility for so many doctors, it was reasonable for Dr Jack to rely on the views of Dr Craig, the Clinical Director in Neurosciences. Dr Craig did suggest getting the views of Dr Gray and a little later Dr McConville, but, unfortunately, it was many months before those reports were obtained, and in the absence of any MS restriction, Dr Watt continued to treat MS patients until June 2017. Dr Craig had also raised his own index case following a clinic on 12th December. This, however, related to Dr Watt diagnosing a patient with Spontaneous Intracranial Hypotension ("SIH") in the absence of objective evidence. In that case, Dr Craig acted immediately to bring the matter to the attention of Dr Jack.
- 15.21 In the view of the Inquiry Panel, concern about preserving the integrity of an investigation process should not have precluded steps being taken to seek clarification of the queries that had arisen. This may have led to an earlier restriction. A further problem, however, was the inability of the Trust to triangulate the relevant information and discern any pattern of potential clinical aberrancy.
- 15.22 In this regard, an issue arises out of the notes made by Mr Watson at the meeting. A handwritten note made by Mr Watson refers back to the concerns highlighted by 3 doctors in the Northern Trust, which had been examined independently by Professor Wills in 2016. The brief note did not reappear subsequently, and the Inquiry Panel asked Mr Watson about the fact that just 6 months earlier Professor Wills had given an independent report, which had essentially agreed with the doctors in the Northern Trust and disagreed with Dr Watt. Mr Watson told the Inquiry Panel in his evidence on 2nd and 3rd November 2021:

It was absolutely in my mind at that stage, and it doesn't surprise me it was in my mind at that stage that there had been a recent previous concern in relation to Dr Watt. My recollection then would be, as it is today, that that was a case that had been closed by November '16.

It would be unfair to say that the Fitzpatrick concerns emerged out of clear blue water, and I haven't suggested they did. And, as you said, I noted down the fact there was a recent history, but the recent history was not of a concern raised by Professor Wills, rather it was a report completed by Professor Wills which, at that time, and subsequently, did not give rise to concerns about Dr Watt in the eyes of myself and others as readers of that report.

15.23 The Inquiry Panel asked why the note was made. Mr Watson explained:

... because it is a matter of fact there was an issue in the previous time. The Fitzpatrick concerns did not come out of clear blue water. I don't know why I chose to write those three words at that time ... I have made the note, I can't go any further as to why I made it, but I will be absolutely clear on this, I didn't make it because I thought there was any unresolved concern in relation to the case, because that was not the case at that time ...

I wish we had reviewed all the history of Dr Watt and the concerns there had been, but we didn't, and the reason we didn't then almost certainly is because we considered, at that stage, that was a closed and concluded matter.

15.24 The Inquiry Panel accepts that Mr Watson believed that the earlier matter was closed and recognise that he is not a qualified neurologist who is in a position to make a clinical judgment.

2nd December 2016:

15.25 On 2nd December, Mr Watson emailed Dr Grainne Lynn of NCAS forwarding the email chain between Dr Craig and Dr Fitzpatrick. NCAS responded immediately, noting the processes that the Trust were intending to follow, and indicating that the case would remain open and that an update on progress would be sought in a few weeks.⁴

15.26 On the same date, a standard letter reflecting the Maintaining High Professional Standards ("MHPS") process, was sent to Dr Watt by Dr Jack. MHPS is the process used across the NHS for managing concerns about doctors. The letter stated:

... I am conscious that a necessary first step for us is to conduct preliminary enquiries (see paragraph 15 on page 8 of MHPS) in order to verify or refute the substance and accuracy of the complaints. I have asked that as a matter of urgency, Dr Craig obtain the relevant patient notes; I note that in at least one case these will be from yourself as the patient is a private patient. I have asked that Dr Craig and a Consultant Neurologist with a special interest in MS, then review the charts in order to advise me if there is substance and accuracy to the complaints. I will then consider what further action (if any) is indicated.

I have also considered if there is any immediate risk to patient safety by your continuing in your current clinical role. I have been reassured by Dr Craig that pending the review of the case notes he does not consider that there is an immediate risk to patient safety such that I would need to consider any

⁴ In written evidence of 5th May 2022 the Belfast Trust pointed out that NCAS did not suggest to the Trust to reconsider INI 286.

restrictions on your practice. You will appreciate that I will need to keep this position under review ...

- 15.27 Dr Jack did not impose any restriction at this juncture but initiated the MHPS process.

5th December 2016:

- 15.28 On 5th December, Dr Fitzpatrick emailed Dr Craig with a further query about a possible index case. Dr Fitzpatrick stated:

John,

I received this letter today from MW [Dr Watt] at [the Ulster Independent Clinic UIC (over a month after the clinic attendance).

I am not a neurologist, but it seems to me that he is saying that despite the complete lack of objective evidence to support intracranial hypotension, he is planning on transferring the patient to the NHS for an epidural blood path. Maybe this is normal practice – I don't know.

This patient has consented to me contacting you about this and I can provide identifiers if required.

Colin

- 15.29 Dr Craig immediately forwarded the email to Mr Watson and Mr Young. Mr Watson responded by return (copying in Dr Jack) suggesting that this new case should also be reviewed by Dr Craig and another neurologist, and that Dr Watt should be advised accordingly. This was the fourth index case.

6th December 2016:

- 15.30 Dr Craig emailed Dr Watt on 6th December, following a meeting earlier that morning, which was also attended by Mr Young. Dr Craig confirmed that Dr Watt had received Dr Jack's letter of 2nd December. The email also recorded the fact that Dr Watt had agreed to co-operate with the investigation process and would provide any relevant medical record in relation to the private patient identified. The email stated that Dr Watt had no concerns with Dr Craig being involved in the preliminary investigation.

15.31 On the same day, Mr Young emailed Mr Watson in the following terms:

Peter,

Since this meeting John [Craig] has spoken with Neurologist Orla Gray from the South Eastern Trust who has agreed to assist John with the investigation.

Michael [Watt] has agreed to provide the notes relating to the private patient however Dr [Colin] Fitzpatrick will need to secure consent from the patients for the others so these can be released.

John and I are keen to conclude this exercise before December if possible so if you could help with securing copies of the others that would be very much appreciated.

Frank

8th December 2016:

15.32 On 8th December, Dr Fitzpatrick raised another case regarding a diagnosis by Dr Watt of inflammatory brain stem disease with a normal MRI. Dr Craig, later that day, emailed Mr Watson and Mr Young to discuss the further case highlighted by Dr Fitzpatrick. This was the fifth index case.

12th December 2016:

15.33 On 12th December Dr Craig saw a private patient at his clinic, who had requested a second opinion regarding her diagnosis of SIH and treatment by way of a blood patch. Dr Craig was concerned about Dr Watt's diagnosis of SIH. This was the sixth index case. Dr Craig disagreed with Dr Watt's view that the symptoms and available investigation results were suggestive of SIH.

15.34 Dr Craig discussed the matter with Dr Jack on the telephone on the evening of 12th December and followed up in writing as requested by Dr Jack in an email of 13th December. The case referred by Dr Craig involved a diagnosis of SIH by Dr Watt. It was agreed by Dr Craig and Dr Jack that there was a potential patient safety issue in relation to this case. In his evidence to the Inquiry panel of 6th February 2020 Dr Craig recalled:

I'm pretty certain that Cathy [Jack] had asked me did I think we need to restrict his practice in the area of epidural blood patching, and I had said, 'yes, we do.'

15.35 Arising out of the meeting, Dr Jack emailed Mr Watson as follows:

Peter

Further concern re diagnostic reasoning in a case of spontaneous intracranial hypotension presented for second opinion privately – potential patient safety issue as treatment has risks associated. Clinical diagnosis queried by second opinion and not supported by imaging etc.

1. Will need restricted practice without prejudice i.e. needs each spontaneous intracranial hypotension cases to be discussed with Thomas Peukert before proceeding with any epidural blood patches.

2. Needs all the cases of spontaneous intracranial hypotension diagnosed by MW [Michael Watt] reviewed by two neurologists. Not by the CD. [Clinical Director] Orla Gray and ? another from outside NI.

3. Need to alert the Medical Director in any private practice setting where MW [Michael Watt] may work.

4. Letter to be drafted for sign off tomorrow am.

Happy to discuss

Cathy

13th December 2016:

15.36 Dr Jack emailed Dr Craig on 13th December 2016. Dr Craig recognised that raising a concern about a colleague was difficult and thanked Dr Craig for his assistance and “*considered advice*”.

15.37 On 13th December a further letter from Dr Jack to Dr Watt under the MHPS framework was drafted. The letter, subsequently received by Dr Watt on 16th December 2016, referred to the case of suspected SIH introduced by Dr Fitzpatrick on 5th December and included the email just received from Dr Craig on 13th December regarding his concerns about another patient, who had sought a second opinion and attended his clinic on 12th December. The letter of 13th December from Dr Jack set out the first clinical restriction, which related to the diagnosis and treatment of SIH was set out in the following terms:

I have considered the totality of the information available to me today, and in particular considered if there is any potential immediate risk to patient safety by your continuing in your current clinical role without restriction. I have been advised by Dr Craig in this regard. Without prejudice to the preliminary

enquiries or any subsequent investigations which may be indicated, I have considered that it is now necessary to place the following restrictions on your practice within the HSC:-

1. When presented with any NEW cases which you consider is indicative of a diagnosis of spontaneous intracranial hypotension, you must discuss the diagnosis and treatment plan with a colleague at consultant grade; the details of who this will be will be provided to you urgently.
2. When presented with any REVIEW case which you have previously considered is indicative of a diagnosis of spontaneous intracranial hypotension, you must discuss the treatment plan with the colleague at 1 above.
3. I have asked that the case notes of those patients who have previously been diagnosed with spontaneous intracranial hypotension by yourself should be reviewed. We will be making urgent arrangements for this review and will be in further contact with you in relation to this.
4. I would ask that you ensure that the Medical Director of each of the private locations where you are currently working, is advised of these circumstances without delay. I would consider that the most transparent way for you to communicate the circumstances would be to share this correspondence and my letter of 2 December 2016 with the relevant Medical Director(s). I should be grateful if you would then confirm to me the individuals that who you have shared the information with by Monday 19 December.

15.38 The Inquiry Panel notes that there is no evidence that the case note review referred to by Dr Jack at paragraph 3 of the letter to Dr Watt in relation to previous diagnoses of patients with SIH was ever carried out. It appears that it was originally intended to ask the RCP to carry out a review of the case identified by Dr Peukert, but the ambit of this review changed whenever the Gray/McConville report was received in June 2017 and it was decided by Dr Jack to ask the RCP to review the ambit of Dr Watt's practice.

15.39 On 13th December, Dr Grainne Lynn, the NCAS Adviser wrote to Mr Watson in the Medical Director's Office and stated:

As per paragraph 22 of section II MHPS the Trust will ensure that Dr [Watt] informs other organisations where he works of the restrictions and the reasons for it.

It is correct to say, as confirmed by Dr Lynn in her evidence of 26th September 2018, that the Trust, as employer, has the obligation to directly inform other organisations, including the private sector, of any restriction on practice or exclusion and provide a summary of the reasons, as per paragraph 22 of

MHPS. Paragraph 76 of Good Medical Practice also states that it is the duty of the practitioner when suspended from an organisation to immediately inform other organisations for which the practitioner carries out medical work that the restriction has been applied.

14th December 2016:

- 15.40 On 14th December, Dr Jack indicated to Mr Watson that Dr Craig, as Clinical Director, should not be involved in the preliminary review of notes, given that he had himself now raised a clinical concern. The letter dated 13th December was formally handed to Dr Watt by Mr Frank Young and Dr Craig on 16th December. Dr Craig's impression was that the various letters did not seem to have a huge impact on Dr Watt. When put to him by the Chairman of the Inquiry that it looked as if Dr Watt did not appreciate how serious the matter was, Dr Craig responded in his evidence of 6th February 2020:

I think it certainly would be fair, and I think others would say the same thing if they were asked, others who were involved in some of these meetings and bringing letters, that there were often discussion at the end that we didn't really understand how he didn't understand how serious this was.

20th/21st December 2016:

- 15.41 Dr Watt appeared to be unsure of the interpretation of the restriction. On 20th December, he emailed Dr Craig indicating that he had a patient admitted whom, he felt, needed a blood patch procedure. Whilst the restriction itself made no reference to epidural blood patching the treatment of SIH can include the use of this procedure. He stated to Dr Craig:

I have a girl who was admitted yesterday who I feel needs a blood patch. What happens now?

A question about the same patient and whether she would be receiving a blood patch was also raised by Sister Vanessa Boyd with Dr Watt. Dr Watt responded and informed Sister Boyd that the patient had been referred by Dr Stephen Hunt for a blood patch procedure and that she was very symptomatic. Dr Watt stated in his email at 12:35 on 20th December: *"Could do her Thursday afternoon, if allowed"*. This email was copied to Dr Craig.

- 15.42 Responding to this email on 21st December, and Dr Watt's earlier email of 20th December, Dr Craig asked Dr Watt whether he could confirm that Dr Stephen Hunt,

Consultant Neurologist, had made the diagnosis of SIH and had referred the patient to Dr Watt to enable him to undertake an epidural blood patch procedure. Dr Craig further stated: *“If this is the case, having discussed things further with Mr Watson and Mr Young the procedure can proceed”*. Dr Watt confirmed within 10 minutes that Dr Hunt had made the diagnosis and that there were changes on the patient’s MRI, which were in keeping with a diagnosis of SIH. He also confirmed that the patient was referred to Dr Watt by Dr Hunt for a blood patch procedure. This was not checked at the time with Dr Hunt. The precise role of Dr Hunt was significant given that the wording of the restriction related to instances where Dr Watt had made or, or was making, the diagnosis of SIH.

- 15.43 The Inquiry Panel heard evidence from Dr Hunt on 9th December 2019. Dr Hunt stated as follows regarding the patient on whom Dr Watt was to perform a blood patch procedure:

This was a patient whom I saw initially on 7th November 2016. I don’t have a letter of referral from her general practitioner, but that is not necessarily an unusual aspect to it. I saw her, took her history, examined her. My initial conclusion was I didn’t actually think that it was likely that there was any major problem wrong. She had symptoms, but I couldn’t identify her having a significant neurological condition. But, because of some of the symptoms that she described, we elected to arrange an investigation. So she proceeded to have an MRI scan of her brain and her cervical spine. The neuro-radiologist found evidence of *“mild tonsillar dissent with prominence of the pons and mid brain. These changes taken together suggest intracranial hypotension as the possible cause of appearances”*. Now that was a little surprising to me because it wasn’t consistent with my pre-test hypothesis that she was unlikely to have a significant neurological problem.

- 15.44 Dr Hunt asked for a further scan of the brain and the entirety of the patient’s spine in addition to a post contrast study. The same neuro-radiologist carried out the scan, which concluded that the features again suggested intracranial hypotension. Dr Hunt subsequently met with the patient and her husband and agreed that she might benefit from seeing his colleague Dr Watt, whom the patient saw one week later. Dr Hunt explained that his letter may not have initially been seen by Dr Watt before he saw the patient. He notes the first line of a letter from Dr Watt after Christmas, which states: *“Thank you for asking me to see [patient] regarding the further management of her intracranial hypotension”*. The following interaction then took place with the Inquiry Panel on 19th September 2019:

Mr Lockhart QC: The impression given in the email correspondence is that (a) you had diagnosed that this lady needs a blood patch –

Dr Hunt: Yes.

Mr Lockhart QC: - and (b) Dr Watt, would you carry it out?

Dr Hunt: Yes.

Mr Lockhart QC: That's not it all –

Dr Hunt: No, that's not the gist –

Mr Lockhart QC: There was a much more nuanced position taken.

Dr Hunt: Yes. So, it's: I have a patient in whom I suspect this may be present, but I have been surprised, due to -. You know, I thought that she was OK. These images have come along, and she's now saying that she's symptomatic. So, I'm asking for an opinion. Now, I may have a reasonable expectation that that then leads to the performance of a procedure, but I'm primarily asking for an opinion.

15.45 Dr Watt sent a further email to John Craig on 21st December in respect of a second patient: *"Any thoughts on [REDACTED] (inpatient 4E) – could you or one of the others see her and say yes or no to patching"*. Dr Craig replied, informing Dr Watt on 21st December 2016 as to the role of Dr Thomas Peukert: *"Michael I have now agreement from Dr Peukert to review cases as they arise. He will need to have discussion with you about cases and be able to review notes which he can then record in. We will need to keep a record of cases and discussions decisions."* Dr Watt immediately confirmed his agreement with this arrangement.

15.46 The question of the interpretation of the partial restriction in relation to the diagnosis of SIH was first considered by Dr Craig, Mr Watson and Mr Young following an email from Dr Craig on 20th December 2016. This email was in response to the earlier query by Dr Watt regarding the patient he had sought to be admitted:

Peter

I do not propose to send you every bit of email correspondence but will obviously keep you and the medical director fully informed if there are any developments. This is, in that patient was apparently referred by another neurologist for the procedure. Dr Jack's letter clearly states in points 1 and 2 that Dr Watt can only undertake epidural blood patching, in cases where he has made the diagnosis, after another neurologist, identified by the Trust has given assurance in regards to diagnosis and treatment plan. As yet we have not been able to secure that individual's involvement. He is awaiting further

guidance from the MDU [Medical Defence Union]. I would be grateful for your view on how to best deal with cases such as this one, i.e. where another BHSCCT has made the diagnosis and is asking Dr Watt to undertake the procedure? In particular, do we need another opinion in this situation?

I will also keep a record of all relevant correspondence.

John

15.47 Mr Watson updated Dr Jack, Mr Young and Mrs Owens in relation to the possible ambiguity about making the diagnosis in an email of 21st December. It was noted that a patient diagnosed by another consultant could be referred to Dr Watt for treatment.

15.48 Dr Jack commented further on this in her oral evidence of 5th February 2020:

It comes back to cases that Michael diagnosed, not, “which you consider indicative”. In the letter of the 13th, and this is being pedantic as doctors are pedantic, but when presented with any new case which you consider is indicative of a diagnosis, you must discuss the diagnosis and treatment plan with a colleague at a consultant grade. So if Stephen Hunt, because Michael was seen as the regional expert it was well recognised that a number of consultants referred things in for Michael to take a blood patch for them where they had diagnosed ... So the big issue here was, it wasn't Michael Watt referring her in. Another consultant colleague had determined she needed it. He was just the technical pair of hands.

15.49 Mr Watson also briefed Dr Jack and Mrs Bernie Owens, the Director of Acute Services in relation to communication with the private sector, the involvement of Dr Gray with a review of 5 cases and the consideration of a case note review of other patients, who had previously been diagnosed with SIH by Dr Watt. The reference to a review of 5 cases should, in fact, have been a reference to 6 cases. This referred to the fact that on 8th December 2016, Dr Fitzpatrick had raised a further case regarding a diagnosis by Dr Watt of inflammatory brain stem disease following a normal MRI. It was this latter case, which seems to have been mislaid for a time.

22nd December 2016:

15.50 On 22nd December, Mr Watson confirmed to Dr Jack and Mrs Owens that Dr John McConville had agreed to assist Dr Gray in relation to the review of cases that had been referred previously by Dr Fitzpatrick and Dr Craig.

23rd December 2016:

- 15.51 On 23rd December, Dr Watt emailed Mr Watson to confirm that he had provided copies of the relevant paperwork to the private sector organisations in which he worked.

29th December 2016:

- 15.52 On 29th December Mr Watson emailed Mr Young regarding the case note review by Dr McConville and Dr Gray:

Frank

I am conscious that the next urgent step in relation to MW [Dr Watt], is the case note review of the 5 cases of concern, by Dr McConville and Dr Gray. They will obviously need to access the relevant private sector notes and so we would need to liaise with Dianne Shanks at Hillsborough and Diane Graham at UIC?

Have you got the patient details to allow us to request the relevant notes etc?

Happy to discuss

Peter

Despite Mr Watson's early proactivity and reminders to Mr Young the notes were not obtained for many months. No explanation provided any good reason why this occurred, although it is accepted that Mr Young was dealing with intense pressures because of winter bed shortages. In such a situation, it would have been better if he had delegated or escalated the responsibility.

3rd January 2017:

- 15.53 On 3rd January, Dr Craig emailed Mr Young indicating that patient consent for the review had been obtained in respect of three patients. Dr Craig also indicated that he had notes in respect of the private patient who had consulted him on 12th December. Dr Craig believed that consent would need to be obtained for two other cases referred by Dr Fitzpatrick. It was also noted that Dr Watt would need to be approached to provide the medical notes for those private patients who had given consent. Dr Watt had already indicated that he would provide the notes, subject to patient consent, following his meeting with Mr Young and Dr Craig on 6th December 2016.

- 15.54 Mr Young suggests to Mr Watson on 3rd January that the Medical Director's Office should contact Hillsborough Private Clinic and the Ulster Independent Clinic. It does not appear that Mr Young realised that Dr Watt had already indicated nearly a month earlier that he will provide the notes subject to patient consent.
- 15.55 On 3rd January, Sister Louise Bell, a Deputy Sister in the Programmed Treatment Unit, had emailed Ms Clare Lundy, Assistant Service Manager for Neurosciences about the possibility of booking in blood patch procedures. This email was copied to Mr Gerry Atkinson, who had earlier emailed Dr Craig because he understood that blood patch procedures were not to be arranged. Dr Craig responded, indicating that blood patch procedures could be done by Dr Watt, but only after cases had been discussed with Dr Peukert. He noted: *"sorry this is all so convoluted, but there is a need to have as few individuals as possible being aware that there is an ongoing issue"*. There was no explanation as to the precise circumstances that were captured by the restriction (regarding who made the diagnosis of SIH). There also does not appear to have been any detailed discussions around how the patients were being booked for appointments, and how this in turn would engage the restriction
- 15.56 Dr Jack addressed the issue of keeping the restriction known to limited personnel this question in her evidence to the Inquiry Panel on 5th February 2020:
- ... it is about confidentiality. Paragraph 39 [of MHPS] isn't exactly great, but a lot of Maintaining High isn't actually great. Employers must maintain confidentiality at all times and they say you shouldn't name them. We did name him when we did the recall, but I think it would be far better. People have a right to know. Those that have key roles have a right to know.
- 15.57 Paragraph 39 of MHPS states:
- Employers must maintain confidentiality at all times and should be familiar with the guiding principles of the Data Protection Act. No press notice can be issued, nor the name of the practitioner released, in regard to any investigation or hearing into disciplinary matters. They may only confirm that an investigation or disciplinary hearing is underway.
- 15.58 The Inquiry Panel believe that, while it is understandable, that this provision may have had a chilling effect on those conducting a disciplinary process, some of the concern is misplaced. Properly understood, paragraph 39 does not prevent a Medical Director from briefing a wider circle of clinicians, on patient safety grounds or where it would otherwise be prudent. The specific prohibition is in making a public pronouncement or issuing a press notice.

- 15.59 The extent to which other neurologists and, in particular, Dr Gavin McDonnell, the Clinical Lead, were informed of the partial restriction is a matter which is considered further by the Inquiry at the conclusion of this chapter. It is noted, at this juncture, that the focus on having as few individuals as possible knowing about the partial restriction caused, in the view of the Inquiry Panel, real problems, which led to confusion and a lack of clarity.

4th January 2017:

- 15.60 On 4th January, Mr Watson sought to summarise the clinical details in respect of five of the patients. One patient was missed. The template prepared by Mr Watson was to be added to by Dr Craig and Mr Young.

12th January 2017:

- 15.61 On 12th January, a draft letter to patients, which had been drawn up by Mr Watson, was sent by Mr Young to Dr Watt seeking his comments on the draft. The Inquiry has not seen any formal response from Dr Watt, but, by 18th January, Mr Watson emailed Ms Claire Cairns, Director of Risk and Governance stating that the letter was agreed and details of the patients had been obtained.

20th January 2017:

- 15.62 On 20th January, Dr Peukert emailed Dr Watt as follows:

Hi Dr Watt

I looked through quite a lot of notes [your secretary] Donna gave me regarding the blood patch situation. As we discussed it does not make a lot of sense to discuss every patient as you won't be able to remember the symptoms in detail and I would make anyway a decision based on the notes.

There will be a lot of patients where I was not able to see the indication based on the notes. I left the notes with Donna. If you have additional details you can let me know and I reconsider.

Hope that's ok.

Thomas

15.63 On the same day, Dr Peukert updated Dr Craig in relation to the situation. He stated:

As there are so many patients on the waiting list [for a bloodpatch] Dr Watt is not able to remember the exact symptoms of individual patients when discussing with myself. For that reason I look through the notes and make a decision depending on letters/ECR.

So far I looked in detail through 20 notes (8 patients I saw myself). Out of these 20 patients I approved 7 for a blood patch. I did not see any indication on the other 13. Nevertheless as [Dr Watt's secretary] and Dr Watt are keen to fill the blood patch clinic every Monday with 3 patients, I looked quickly through another 49 notes to find a potential patient. I was not able to find a clear indication in any of the 49 patients, but will look in more detail when back from leave. These decisions are based on what is written in the notes/letters and ECR. As far as I can see, only 1 patient out of 69 has findings of low pressure headache on MRI. Nevertheless I have to review the 49 patients in more detail.

I am aware I should discuss the patients with Dr Watt instead of review the notes and the ones I approve were discussed. I will make Dr Watt aware of the ones I did not approve and he can come back to me with more details if he feels it's needed.

22nd January 2017:

15.64 Dr Peukert's email was forwarded on 22nd January to Mr Young by Dr Craig, stating:

Hi Frank

Can we meet to discuss? Wait to see outcome but concerning.

John

3rd February 2017:

15.65 An Excel spreadsheet prepared by Dr Peukert, which listed patients who had been considered for a blood patch procedure by Dr Peukert, was forwarded to Ms Lundy on 3rd February.

15.66 Dr Peukert's email and subsequent Excel Spreadsheet was a significant moment, because it confirmed for the first time, that not only had the partial restriction been fully justified but that the extent of the problem was beyond anything anyone had to this point understood or even imagined. Commenting on this in his evidence to the Inquiry on 6th February 2020 Dr Craig stated:

I don't think we did meet. That number is clearly outwith because these are the ones that are waiting to be done as opposed to the ones that have been done ... concerning number because that's way outwith what we thought was happening.

15.67 Mr Young in his evidence of 22nd April 2021 believed he would have met with Mr Craig at this time. In his evidence of 22nd April 2021, he stated:

I have no doubt that when that report was produced that that would have been shared immediately with Bernie Owens as the Director. Why the Medical Director's Office doesn't know about it for a number of months I can't answer. I find that very difficult to believe that they wouldn't have known about something of this significance, because there's a direct patient safety issue for a number of patients, not just one or two.

15.68 Mr Watson during his evidence of 2/3 November 2020 was clear that the Medical Directors Office did not see the Peukert Spreadsheet until March, and this was also the evidence of Dr Jack and Mrs Owens.

15.69 The Inquiry was aware that Dr Craig had to take extended time off during this period for family reasons and it seems likely that the document was not passed to the Medical Director's Office for some weeks. Given that its importance was recognised it was incumbent on Mr Young, especially if Dr Craig was absent, to ensure the Medical Director was aware of the document. Given subsequent events between Mr Young and Dr Hunt, which are discussed below, it appears to the Inquiry Panel that Mr Young did not grasp the seriousness of what Dr Peukert had uncovered at the time.⁵

10th February 2017:

15.70 On 10th February, Mr Atkinson emailed Dr Craig asking whether a mechanism had been agreed for informing patients that their blood patch procedures would not proceed following Dr Peukert's review. The Inquiry believed this was an appropriate query to raise but has not had sight of any written response to this query.

⁵ It is accepted that Mr Young is not a medical professional and is not in a position to make clinical judgements.

13th February 2017:

- 15.71 The first Early Alert⁶ was forwarded to the Department of Health following a phone call to Dr Paddy Woods, Deputy Chief Medical Officer, on 13th February. A summary of events was set out in the Early Alert as follows:

Concerns have been raised in relation to the practice of a Consultant Neurologist (employed by BHSCT) in relation to 5⁷ patients, both in relation to practice in the NHS and the private sector.

The BHSCT is initiating an independent review of these 5 cases by two Consultant Neurologists seeking assurance regarding the care provided or clarification as to whether the concerns are substantiated.

The BHSCT will be writing to each of the 5 patients advising them of the action being taken, with the correspondence copied to the relevant GPs.

The BHSCT will liaise with the Consultant Neurologist regarding the provision of records of care in the private sector and with one other Trust in NI where one of the patients was also seen.

On the basis of the findings of the review of these charts, further action will be considered as necessary.

The Trust has taken steps in the interim to ensure that patient safety is protected.

- 15.72 Dr Brid Farrell was the Designated Review Officer (“DRO”) for the Early Alert within the Public Health Agency (“PHA”). In her evidence of 4th November 2019, she told the Inquiry Panel:

OK. Well, when the early alert comes through, and that is now to allow early notification to the Department of an incident that might require action or something to follow. And the question that would be asked of Lead Officer is, “Is there any action that we need to take?” And, based on the information provided in that alert from February 2017, it would be a question of waiting to see what turned up, based on a review of the initial five patients.

It is noted that no mention is made in the Early Alert of Dr Watt being partially restricted in his practice.

⁶ The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent action by the Department. Based on the principle of “No surprises” and an integrated approach to communication HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets specific criteria.

⁷ The reference to 5 patients is an error, which had occurred in various manifestations since December 2016. It should have been 6 patients.

14th February 2017:

- 15.73 Ms Lundy emailed Dr Craig about a sixth case, which appeared to have been overlooked since December 2016. Dr Craig responded that he was no longer involved in the investigation because he had identified one of the index cases in December. Ms Lundy then contacted Mr Watson, who referred her to Mr Young and the patient's Health & Social Care number was identified that same day.

15th February 2017:

- 15.74 On 15th February, Dr Peukert queried whether neurosurgical consultants as well as consultant neurologists should be regarded as competent to make the diagnosis of SIH. If that was the case, then Dr Peukert would not be required to reassess the patient prior to Dr Watt undertaking a blood patch procedure. Dr Craig confirmed that, in his view, a neurosurgeon was in the same position as a neurologist. On the same day, Dr Peukert indicated that he was now reviewing about 10 patients every week, whom Dr Watt had listed for a blood patch procedure and requested an additional programmed activity unit to enable him to incorporate the work into his job plan.

21st February 2017:

- 15.75 On 21st February, Mrs Dianne Shanks, the manager of Hillsborough Private Clinic, ("HPC"), emailed Dr Watt asking whether he had the relevant insurance to enable HPC to approach the RQIA for registration of the blood patch procedure to be carried out at the HPC even though Dr Watt had already informed HPC that he was operating under a partial restriction. Dr Jack told the Inquiry Panel in her evidence of 5th February 2020, that Mrs Shanks had confirmed to her that she had received confirmation from Dr Watt that he had been placed under a partial restriction and that this was, in fact, discussed by the directors on 3rd January 2017. The Inquiry has not seen any evidence that blood patch procedures were, in fact, undertaken at the HPC although it notes that the procedure was at one stage being contemplated.

24th February 2017:

- 15.76 On 24th February, Mr Young emailed Dr Watt asking him to forward the clinical notes of the 6 patients whose Health & Social Care numbers were listed. The notes of private patients were held by Dr Watt and not at the Ulster Independent Clinic or the Hillsborough Clinic. This was approximately 3 months after it was decided to initiate the review by Dr Gray and Dr McConville.

- 15.77 On the same date, letters to the 6 patients' GPs were posted. These had been discussed and reviewed by Dr Craig before sending out and then forwarded to Mr Young on 14th February.
- 15.78 The delay in obtaining the notes of the patients who were the subject matter of review by Dr Gray and Dr McConville was unacceptable. Once it had been determined that Dr Craig should not be involved in the process, because he had himself raised one of the case of concern, an alternative method of progressing the matter should have been agreed.

27th February 2017:

- 15.79 On 27th February, Mr Young emailed Mr Watson asking if he wished that the letters intended for the relevant patients, which had previously been forwarded to their GPs on 24th February, should now be sent from the Trust to the patients who were the subject of the review. Mr Young decided that these letters should be deferred until Dr Craig returned to work. It does not appear to have been fully appreciated that Dr Craig was not a part of the process given that he had highlighted a case of concern which became one of the 6 index cases.

3rd March 2017:

- 15.80 By 3rd March, the private notes in the possession of Dr Watt had not been forwarded as requested. Consequently, Mr Watson wrote to Mr Young (copying in Dr Jack and Mrs Owens) suggesting that a deadline of 10th March be imposed and additionally, that in the event of a continued failure by Dr Watt to provide the notes, the matter would be escalated to the Medical Director and the Director for Acute Services. Mr Young corresponded with Dr Watt on the same day in the following terms:

Michael

As per my email of 24th February I understand that Clare Lundy has yet to receive any of the private patient notes from you as part of this preliminary investigation exercise

I therefore need to advise you that if the notes are not forwarded by 10th March I will have to escalate this matter to Mark Mitchelson, Chair of Division, Bernie Owens and Cathy Jack Medical Director.

Regards Frank

13th March 2017:

- 15.81 On 13th March, Ms Lundy indicated to Mr Watson that the notes had not been received. Mr Watson suggested on the same day to Mr Young that it may be worth his meeting with Dr Watt.

15th/17th March 2017:

- 15.82 Mr Watson emailed Dr Craig on 15th March asking him to assist in persuading Dr Watt to release the relevant private notes and records as Mr Young was on leave. Letters to the 6 patients involved were also sent at this time.

16th March 2017:

- 15.83 On 16th March, Dr Craig wrote to the Medical Director, Dr Jack, in the following terms regarding the review process being carried out by Dr Peukert:

Dear All

Dr Peukert has been reviewing those patients awaiting epidural blood patching. He informs me that he still has at least another 15 cases to review. Of the 87 that he has reviewed he has opined that 12 meet criteria, 1 needs further information and the rest do not meet with criteria based on information he has been provided.

We obviously need plan for how to move forward. In essence 74 patients have been informed by Dr Watt that they should have this treatment and they will not now be receiving it. Some have already been asking about when it will be taking place and what is the delay.

Can I please have steer on how to progress? I suspect some of us need to meet.

John

- 15.84 Dr Craig indicated that he would speak to Dr Watt the following day. Mr Watson followed this up on 17th March asking whether Dr Craig had been able to speak with Dr Watt. At the same time, on 15th March, the letters, which had been previously deferred, were sent out to patients, their GPs having received same on 24th February. In addition to the numbers of patients involved, Dr Craig pointed to the situation in on the ground, where patients had been informed by Dr Watt that they would receive a blood patch and, were booked in for the procedure, only for the treatment to be cancelled.

22nd March 2017:

- 15.85 On 22nd March, Mr Watson emailed Ms Lundy to follow up on the question of obtaining access to the patients' notes. Ms Lundy replied:

I did remind MW on Monday morning when I met him in Ward 4E. I advised him I needed the information on or before Wednesday. I am off today, but I do have a meeting with him on Friday afternoon regarding a separate issue so I can pursue the notes then if you wish.

23rd March 2017:

- 15.86 Dr Craig summarised the findings of Dr Peukert's own review. Subsequently, a meeting was subsequently arranged for 23rd March 2017 to include Dr Jack, the Medical Director, Dr Craig, the Clinical Director, Dr Mark Mitchelson, who had been in post since January 2017 as the new Co-Chair of the Neurosciences Division on the medical line, and Mr Young, who was the other Co-Chair on the managerial line.
- 15.87 Following the meeting, Dr Jack sent out a note of agreed points by email of 23rd March. The email stated:

Dear John and Frank,

Following our meeting today re MW [Dr Watt] the following were agreed.

1. Active index cases MS patients and ? epilepsy – currently under review by two independent consultants. Report should be ready in 4/52.
2. Mark Mitchelson to write to college⁸ [Royal College Physicians] requesting independent neurologist to review 75 potential SIH patients offered epidural patch. This will allow second review.
3. New cases to be processed as agreed with TP [Dr Peukert] reviewing and if appropriate proceeding with Epidural patch. If not thought appropriate to be reviewed by college [Royal College Physicians] rep.
4. Review MW data base for epidural patch procedures and cross check this with clinical coding department. This will ascertain total numbers of patients undergoing this treatment over the database period.
5. Develop key anchor statements for secretarial staff in case of patient queries while the review is under progress.
6. No new safety concerns into MW practice so no changes in restrictions

⁸ This is the first mention of the matter being referred to the Royal College of Physicians.

required currently. Restriction re second opinion for all proposed epidural patch treatments. Restrictions to be kept under regular review.

7. Meet again on the 2nd May at 8.30 KEB or earlier if number 1 completed or further issues arise.

8. Cathy to discuss with P Watson re GP involvement and info given to index cases.

Hope this captures the agreed next steps.

Thanks again for all your help with this

Cathy

15.88 In a handwritten note of the meeting, Dr Jack recorded: *“(ii) No other concerns – checked with clinical lead – none, and d/w C lead re trainees – no concerns”*. When asked about this by the Inquiry Panel on 5th February 2020, Dr Jack stated:

Dr Jack: No other concerns. Checked with Clinical Lead. None.

Mr Lockhart QC: Clinical Lead is presumably not Gavin McDonnell?

Dr Jack: It is.

Mr Lockhart QC: It is Gavin McDonnell.

Dr Jack: The Clinical Lead in neurology is Gavin McDonnell.

Mr Lockhart QC: We thought, you have seen Gavin McDonnell’s evidence. He said he didn’t know anything.

Dr Jack: I can only tell you what I have written here. Also discussed with Clinical Lead re trainee concerns. None.

Professor Mascie-Taylor: At that point Gavin McDonnell tells you?

Dr Jack: He doesn’t tell me. It is reported back to me by Frank and John. Gavin is not at this meeting.

Professor Mascie-Taylor: I understand that, that’s why I’m asking the question, Cathy. It was reported back to you that Gavin McDonnell had no concerns and that the trainees had those concerns. Who reported that to you?

Dr Jack: There was two people at the meeting apart from me, Frank and John.

Professor Mascie-Taylor: Do you know which of the two? You might not know, but do you know which of the two?

Dr Jack: No.

Professor Mascie-Taylor: You understand why I'm asking the question?

Dr Jack: Yes, I do.

Professor Mascie-Taylor: It is crucial, isn't it? You were told at that meeting by either Frank or John.

Dr Jack: It would appear that I was told, yes.

15.89 The Inquiry Panel probed this issue further with Dr Jack:

Professor Mascie-Taylor: I want to give you the opportunity to be absolutely clear about this. You, at that meeting, put the question to John and/or Frank had they checked with the Clinical Lead were there any concerns and had they checked whether there were any concerns from the trainees. Neither of them, neither Frank nor John indicated. It is dancing on the head of a pin and you may not know, but did you say to them 'does the Clinical Lead know of any concerns from the trainees or are there any concerns of the trainees?' You know exactly what I am driving at, I think.

Dr Jack: You know what, all I know is that I have written there are no other concerns. Checked with the Clinical Lead, none. Also discussed with the Clinical Lead re trainees, no concerns'.

Professor Mascie-Taylor: Right.

Dr Jack: Actually I think that is a specific but that's how I read this note.

Mr Lockhart QC: We certainly read it on the basis that you have raised the question. When you say 'check with the Clinical Lead about concerns', is that about Clinical Lead concerns in a broader way or is that talking about?

Dr Jack: This will be any other concerns. So the one is broader and then specifically, because apart from the TIA Clinic he did a lot, so what about the trainees?

Mr Lockhart QC: This would have been the obvious place to tell you about HIG, to tell you about the outlier in alemtuzumab, to tell you about the continual number of complaints that came in.

Dr Jack: You know what, and you are right, but the one thing is I think, because he always practised in that way, did they see that as a concern? So he didn't go off in the last six months. I think the immunoglobulin and the second line DMTs were years. So I'm just being devil's advocate here, did they actually even think it was a concern because he had always done it that way?

15.90 At the heart of the Inquiry Panel's concern was the fact that Dr Craig would have been aware that some years previously, in June 2013, Dr Ingrid Hoeritzauer had

come to him with concerns about Dr Watt and the matter had not been escalated. Further, Dr Hoeritzauer had subsequently raised concerns with Dr McDonnell, which had not been amplified at the time, despite efforts by Dr McDonnell to follow the matter up (Dr Hoeritzauer had moved to Edinburgh to take up a new post). Additionally, another registrar, Dr Jamie Campbell, gave evidence that he too had concerns about Dr Watt, which he had sought to voice at a meeting of registrars in or about 2014. The Inquiry also noted that Dr Ellen Campbell had specifically raised concerns in 2013 with Dr Jim Morrow about the treatment of two patients, who had been diagnosed with epilepsy and who were due to give birth.⁹ While the Inquiry Panel accepts that aspects of Dr Watt's clinical practice may not have caused concern to his Consultant colleagues, the same cannot be said about the registrars who worked closely with him.

- 15.91 The Inquiry Panel believes that Dr Jack did raise the question of the views of clinical trainees regarding Dr Watt and was reassured. This was a missed opportunity for the Clinical Director, Dr Craig, to pause and reflect and, at the very least, discuss with Dr McDonnell in some depth their collective memory of earlier concerns being raised. The Inquiry Panel believes that the reference to checking with the Clinical Lead may refer to the Clinical Director as, at this point, Dr McDonnell was not aware of the concerns around Dr Watt or the process that was in train. The impression given is that the focus was on the issues that were being considered and that little thought was given to earlier problems. Further, neither Dr Craig, Dr Jack nor Mr Frank Young seem to have considered the Northern Trust concerns relating to the treatment of stroke in early 2016, nor did Mr Young or Dr Craig inform Dr Jack of issues relating to Dr Watt, which had necessitated a meeting on 30th August 2016.¹⁰ The matter had been raised by other consultants in a different Trust and the issue had remained a potential problem (or would at least have been relevant in terms of pattern recognition) even after the obtaining of an independent report.

24th March 2017:

- 15.92 The notes were obtained by Ms Lundy from Dr Watt on 24th March. Ms Lundy suggested by email of the same day that the notes be given to Dr McConville, one of the independent reviewers, when he was due to attend the neuromuscular meeting at the Royal Victoria Hospital on 27th March.

⁹ These concerns are set out in detail in the Concerns chapter.

¹⁰ See para [93] at 2016 Missed Opportunities chapter.

15.93 The fact that it took nearly 4 months for the notes to be obtained is unacceptable in any management system. The delay suggests that there was really no urgency to the investigation being carried out and was compounded by a degree of confusion as to who was responsible for ensuring that the notes were obtained. The Inquiry does note the persistence with which Mr Watson pursued the matter, but decisive action should have been initiated as soon as there was any suggestion of unreasonable delay.

15.94 The Inquiry Panel noted Mr Watson's insistence that it was the responsibility of the Neurosciences Division to obtain the notes. In his evidence on 3rd November 2020 Mr Watson told the Inquiry Panel:

It was very clear in those arrangements back then, that the management of concerns involves not just the Medical Director's Office but the staff in the Division. In this context the particular aspect of the management of concerns was securing this expert report, or expert reports from McConville and Gray. Chairman, I would suggest that's an entirely reasonable proposition to seek support on a Division or a Directorate in that particular task. It's not a difficult task. It's not an impossible task. It's not even an inordinate amount of work... part of me does wish I had done it myself, because I think it would have happened. I would have got the notes. My PA would have been looking for it. She would have been merrily photocopying notes in January, and had them out to McConville and Gray with clear instruction

15.95 Mr Watson clearly proceeded on the basis that it was the responsibility of Neurosciences to organise the notes and his many reminders bear that out. Without his persistence the delay may have been longer. Nevertheless, once it became clear that delay was inordinate it would have been wiser to have referred the matter to Dr Jack to discuss directly with Dr Watt. The Inquiry Panel accepts that the Neurosciences Division had taken on the responsibility of obtaining the notes. The matter was complicated by the fact that Dr Craig, as Clinical Director, had been removed from the process, even though at times he had been asked to assist. Undoubtedly, the Neurosciences Division must bear responsibility for failing to obtain the notes in a prompt manner. That is, however, not the end of the matter.

15.96 The MHPS process is ultimately controlled by the Medical Director's Office, and it is not acceptable for the delay to have gone on for such a long period. The Inquiry Panel cannot work out the precise division of responsibility as there was no document within the Trust which highlighted who should do what with regard to Dr Watt. There was an insufficient degree of urgency within the Neurosciences Division, and this should have ultimately caused the Medical Director's Office to

take action. That might have involved requiring Dr Watt to meet with the Medical Director or involving Mrs Owens as the Director for Acute and Unscheduled Care. The method actually adopted of Mr Watson reminding, suggesting and cajoling Mr Young did not elicit the kind of prompt response that was necessary.

27th March 2017:

- 15.97 On 27th March, Mr Watson, responding to Ms Lundy in relation to the disclosure of the notes, indicated that it was best *“you are guided by Frank in relation to the process for review”*.
- 15.98 On 27th March, Dr Stephen Hunt, having intended to speak to Dr Craig and being unable to find the Service Manager, Mr Atkinson, met with Mr Young in relation to a request that had been made by Dr Watt regarding five of his private patients. Dr Watt had diagnosed SIH and concluded that each of the patients required a blood patch procedure within the NHS. He had asked Dr Hunt to endorse his diagnoses and proposed management. Dr Hunt was not aware of the details of any partial restriction in respect of Dr Watt. Dr Watt explained to Dr Hunt that, in respect of patients being diagnosed with SIH, a second opinion was required. Dr Hunt agreed to see 5 of Dr Watt’s patients. Following his examination of the patients, Dr Hunt concluded that there was a disagreement between Dr Watt and himself about the appropriateness of the diagnoses. He was also concerned that patients may have been having blood patch procedures, without fully understanding the nature of the procedure and its potential complications. He indicated in his evidence to the Inquiry Panel on 9th September 2019, that the extent of disagreement was greater than he had previously ever experienced between himself and a colleague.
- 15.99 As a result of that disagreement, Dr Hunt felt he needed to speak to somebody. He met with Mr Young and recalled saying to him: *“I’m not saying that he [Dr Watt] is wrong and I am right. I am just telling you that there is a difference”*. At that stage, he had not discussed the matter further with Dr Watt because he was not content that he had understood the whole position. When asked about this by the Inquiry Panel on 19th September 2019, Dr Hunt indicated that Dr Watt had been of the view when he asked Dr Hunt to examine his private patients, that there would be no disagreement over diagnoses between himself and Dr Hunt. Referring to his meeting with Mr Young, Dr Hunt gave evidence to the Inquiry Panel as follows:

I trusted Mr Young was in a position to do something about it. So, I brought it to him, we spoke about it. My intention was that I would convey the information in a manner that was clear that it needed to be acted upon. So, it’s got nothing

to do with formal or informal, and it's got nothing -. There is no part of that conversation where I said, "I want to keep this off the record. I want this to be informal". Ok? So, I do not recognise that.

- 15.100 Dr Hunt's concern regarding the nature of his communication arose from an email that was sent to him by Mr Young on 27th March at 14:41, following their meeting, which stated as follows:

Stephen

Following our earlier conversation, in John's [Craig] absence I spoke with Mark Michelson our new appointed Chair of Division who agreed with me that you should not be undertaking any referrals from MW [Dr Watt] for blood patches. John, Mark and myself will meet with Michael just as soon as diaries allow when John gets back to clarify matters. I did make clear to Mark that our conversation was an off the record informal one.

Hope this helps but if there's anything in the meantime don't hesitate to get in touch.

Regards Frank

- 15.101 In his evidence to the Inquiry Panel on 16th May 2019, Mr Young stated:

He came to me with those concerns and then he – again, it goes back to my previous comments, where he didn't really want to make it formal and I respected that. I spoke to John Craig as the CD [Clinical Director]: "Tell Michael to stop and desist and not to be putting that kind of pressure on a peer to do something"

On reflection and in hindsight knowing what I know now, I think that I would have had the courage to say to Stephen Hunt, "I can't unhear your comments. You've told me that this is informal" I would have had to decline and say "It's formal". It's a lesson that I have learnt.

- 15.102 The Inquiry notes that Dr Hunt did not challenge at that time, Mr Young's description of the meeting as "*off the record*". In the view of the Inquiry Panel that is irrelevant. While it may be that Mr Young formed the impression that there was a degree of informality the fact remains that Dr Hunt was bringing the matter to Mr Young as Co-Director, not as a colleague. The meeting took place in a context where partial restrictions had been imposed. The obligation on Mr Young was clear whether the information was formal, informal, or 'off the record'. He had been clearly informed that a doctor operating under a partial restriction had been seeking to circumvent that restriction. In that situation the Medical Director should have been informed immediately.

28th March 2017:

- 15.103 The wife of patient INI 399 made a complaint to the Complaints Department regarding the care received while INI 399 was in hospital in January 2017. The patient was kept in hospital from 12th January to 24th January awaiting a blood patch. The procedure was carried out on 23rd January. During that period, INI 399 was immobile and had to remain in bed because of his problems with balance and headaches. Following his discharge, he suffered a pulmonary embolism and a partially collapsed left lung. The substance of the criticism was that the patient had not been given blood-thinning medication during the period when he was immobile for nearly two weeks awaiting the procedure.
- 15.104 This complaint is significant because, it related in part to blood patching and because a Serious Adverse Incident (“SAI”) was called in respect of the complaint. The Inquiry has not had sight of any final complaint response issued in respect of INI 399, some 5 years later. This calls into question the utility of the SAI process itself in respect of INI 399.

30th March 2017:

- 15.105 On 30th March, the Health & Social Care Board emailed the Trust asking whether the Trust intended to call a SAI in respect of the issues that had arisen in neurology. This inquiry emanated from the Early Alert notification on 13th February 2017.

6th April 2017:

- 15.106 On 6th April, the minutes of a confidential Trust Board meeting make no mention of any issues in neurology; although, by February 2017, an Early Alert had gone to the Department of Health, Dr Mitchelson had been asked to liaise with the Royal College of Physicians, and Dr Watt had been partially restricted in his practice¹¹.

10th April 2017:

- 15.107 On 10th April, Mr Colin McMullan from Risk and Governance wrote to Ms Roisin Hughes, a Governance Support Officer within the Health & Social Care Board. This was in response to the query on 30th March as to whether the Trust would be carrying out a review and submitting an SAI, subsequent to the Early Alert. The body of the correspondence stated:

¹¹ In written evidence of 5th May the Belfast Trust pointed out that Trust Board members now receive copies of Early Alert Notifications as they are issued and Early Alert Notifications are an item on the agenda of the Confidential Trust Board meetings to enable Board members to ask questions. The Inquiry welcomes this development.

Further to your recent query in relation to the above Early Alert the Trust would advise as follows:-

- Can you please advise if the Trust will be carrying out a review and submitting a SAI in relation to the above Early, and if not, why not?

The directorate has advised that an investigation is currently being undertaken to address concerns raised by a GP. At present, they have no evidence to suggest that any patient has come to any harm however if any harm or serious risk to patients is identified as part of the investigation, the case will then be considered for reporting as an SAI.

15.108 When asked about the response given, Dr Jack addressed the matter candidly in her evidence of 5th February 2020:

On 13th February there were issues of concern. There was possible harm. The statement that I signed off on 10th April saying no potential serious risk wasn't right, and I apologise for that. I went back through that day. I had 174 emails. This wasn't an email, this was a conversation. That's a slip, trip or lapse from me. Okay. I got that wrong and that wasn't right. We should have said because of the steps we have taken we believe that the potential harm in epidural blood patches has been addressed but we are still awaiting the MS and the seizure.

12th April 2017:

15.109 On 12th April, Ms Lundy emailed both Mr Watson and Mr Young because she had been contacted by Dr McConville to ask for clarification and written confirmation regarding his role, and that of Dr Gray in relation to the case note review of 6 index cases. Mr Young immediately responded that he would get back to Ms Lundy.

13th April 2017:

15.110 As a result of his meeting with Dr Hunt, Mr Young met with Dr Watt on 13th April. It appears that both Dr Mitchelson, the newly appointed Co-Chair of the Division, and Dr Craig, the Clinical Director, were present. Neither was able to assist the Inquiry in their recollection of what transpired at the meeting. The most contemporaneous evidence is contained in a memo between Mr Young and Dr Mitchelson of 17th May. In that memo, Mr Young refers back to the meeting of 13th April:

Since the meeting of 13th April Dr Watt confirmed he had not forwarded any further requests since the meeting and that these must be the remainder of old referrals continuing to trickle through. Dr Watt again confirmed that he was in full compliance with the restriction letter issued by the Medical Director in December 13th.

Dr Watt stated that he was very frustrated with the restriction process and felt that no other Neurologist or Neuroradiologist had his level of expertise and that he remained best placed clinically to determine which patients would benefit from a blood patch procedure.

- 15.111 In an email to Dr Watt of 14th April, Mr Young reminded Dr Watt that the restriction applies equally to the NHS and Independent Sector consultations.

Michael

Thank you for attending the meeting with Mark, John and myself yesterday.

I just wanted to confirm that until the preliminary investigation is complete the restriction on your clinical practice apply equally to both NHS and Independent Sector consultations.

Clearly this is a very stressful time for you so would again like to remind you of the support the Trust's Occupational Health Service can provide, I would be happy to organise an urgent appoint, although you may prefer to self-refer.

- 15.112 In his evidence to the Inquiry on 16th May 2019, Mr Young stated as follows in relation to Dr Hunt:

So, that's why he raised the concern, came to me, wanted to make it informal. I raised it with John. [Craig] It would've been discussed with Mark [Mitchelson]. And it was made very clear to Michael [Watt] that he stopped and desisted.

But, in hindsight, you know, knowing what we know now and about the processes and more up to speed with things like duty of candour, that would've been a much more robust conversation.

Mr Lockhart QC: They didn't know about it at that time. Subsequently, has that interaction ever been the subject of a discussion with, say, Bernie Owens and/or Cathy Jack?

Mr Young: It would definitely have been at some stage.

Mr Lockhart QC: Right. At some stage.

Professor Mascie-Taylor: At some stage down the line. You wouldn't, at that time, have discussed it with Bernie Owens.

Mr Young: I can't recall having a - .

- 15.113 Dr Jack, in her evidence to the Inquiry Panel on 5th February 2020, was clear that at no stage was she aware of the conversation with Dr Hunt. She indicated to the Inquiry Panel: *"I would have expected and required it to be escalated and, in fact, I wrote any new issues and we'll meet earlier."*¹²

¹² This refers to the email (at point 7) sent out following the meeting on 23rd March 2017.

15.114 The following exchange took place between Professor Mascie-Taylor and Dr Jack:

Professor Mascie-Taylor: If this issue were to be dealt with then it would have to come to you, wouldn't it?

Dr Jack: Yes, and this is a probity issue.

Professor Mascie-Taylor: The people in that room couldn't have dealt with it.

Dr Jack: This was a restriction that I placed on him as RO [Responsible Officer] He [Dr Watt] was not complying. It is for me to deal with.

Professor Mascie-Taylor: Placed on him as Medical Director.

Dr Jack: Yes. Both.

Professor Mascie-Taylor: He was ignoring it.

Dr Jack: Because it extended beyond. This is him in UIC, [Ulster Independent Clinic] so it extends beyond Belfast.

Professor Mascie-Taylor: Sure. If the matter were to be dealt with it would be a matter under Maintaining High [MHPS] would have to come to you? There would be no other process available, would there? Equally, if it is not brought to you would you agree with it can't be dealt with?

Dr Jack: Yes, because I have to put the restrictions on.

15.115 The Inquiry Panel has concluded that Dr Jack was not aware of the interaction between Dr Hunt and Mr Young. She clearly should have been and the failure to bring the matter to her attention was a serious omission by Mr Young.

14th April 2017:

15.116 On 14th April, Ms Lundy emailed Dr McConville, having discussed the matter with Mr Young. She informed Dr McConville that the guidance was to review the medical charts of named patients and provide an opinion as to:

- Whether suitable diagnostic processes were followed?
- Whether the final diagnosis was reasonable?
- Whether there was reasonable consideration of differential diagnoses?
- Whether a blood patch was reasonable and clinically appropriate?

15.117 On 14th April, a draft letter to GPs in respect of patients who were due to receive, but had not undergone an epidural blood patch procedure, was continuing to be

discussed by Mr Young and Dr Jack. Dr Jack had drafted a template, but, after Mr Young had discussed the matter with Dr Craig and Dr Mitchelson, Mr Young raised a number of queries. Consequently, no letter was sent out at that stage. In the view of the Inquiry Panel, the letters should have been sent out and the delay was not justified.

24th April 2017:

- 15.118 On 24th April, Dr Peukert contacted Dr Craig and Dr McDonnell regarding a patient who had been diagnosed with multiple sclerosis by Dr Watt and had been prescribed *Tecfidera*.¹³ None of the four MRI scans performed had shown any evidence of demyelination and Dr Peukert had earlier been contacted by a medical consultant and a neurology registrar, both of whom doubted that the patient had received the correct diagnosis. Dr McDonnell decided to arrange for an additional MRI scan, which was carried out on 5th June 2017. Once again, this scan did not show any evidence of demyelination.
- 15.119 In his evidence to the Inquiry Panel, Dr Peukert was quite clear that he was raising a concern with Dr Craig, Clinical Director for Neurosciences, and Dr McDonnell, Clinical Lead for Neurology. Dr Craig fully accepted in his evidence that this matter should have been referred immediately to the Medical Director. The Inquiry Panel asked Dr Craig specifically about this during his attendance on 5th November 2020:

Mr Lockhart QC: ... The concern here, John, is that in April, Thomas [Peukert] is raising a concern to both you and Gavin McDonnell about an MS case. It is not as if you don't say let's go and investigate this, because it is clearly done.

It looked like it is an index case of concern and should have been immediately escalated to Cathy. [Jack]

Dr Craig: I accept that. I don't remember exactly when it was. I do have a recollection that Thomas just came to my office and told me about it. I think it is absolutely accurate that I said that he should discuss it with Gavin. [McDonnell] I don't know whether Thomas or the Registrar had seen the patient, but it is absolutely fair to say that he was raising some level of concern. I totally accept that while trying to get the patient sorted out was the right thing to do, it should have become an index case and the Medical Director should have been aware of it.

Professor Mascie-Taylor: ... have you any thoughts at all on what it is that stops people or stops you from escalating? ...

¹³ *Tecfidera* (dimethyl fumarate) is a disease-modifying drug used to treat relapsing remitting multiple sclerosis.

Dr Craig: I suppose the starting point is that again I didn't know what the results or what the outcome was going to be of John McConville and Orla Gray's review of the notes.

Professor Mascie-Taylor: Indeed.

Dr Craig: But I knew it was taking place. I knew it was supposed to -- and I am not offering this as an excuse, but I would have known that that was out to report quite soon.

Professor Mascie-Taylor: Sure.

Dr Craig: But this is something I think we have all struggled with through this entire process, because certainly if we take it forward, and it is similar, but maybe different, into the recall phase, we were seeing things that in any other time I think we would have immediately been going straight to the Medical Director or the GMC in terms of things that we saw. But we knew an investigation was taking place, and we knew there was going to be an outcomes report, and we knew that somebody was going to be going through that systematically; so does that usurp the normal processes or does that still have to be done independent of that? There clearly was opportunity where we were specifically asked by the GMC for cases that we had seen that highlighted certain areas or whatever. It is maybe just a failing on my part that there was an expectation that everybody should know exactly what to do, but I think when you are caught up in this sort of thing and you've never done it before, it is kind of difficult to know at what point in time. I mean, there was an earlier email from me at one stage. I think it is about the Stephen Hunt and Michael Watt interaction around Christmas time where I say, 'I am not going to send you an email on every single thing that comes across my desk, but if I think I need a question I will ask it'. I don't think it comes down to, on my part, a reluctance or a positive. I think it is an active omission rather than commission. I don't think I have actively decided that I am going to withhold this for whatever reason that might be; it just wasn't done. Whenever I look at now, again I immediately spotted it whenever you sent out the transcripts it was, this should have been highlighted, because this was four weeks potentially before the decision was made about the MS drugs. There must be people in all of the Trusts who have been through this sort of thing before. Most of us haven't been, even those of us who sit in certain management positions.

- 15.120 The Inquiry Panel accepts Dr Craig's candid acknowledgement that this case should have been escalated immediately to the Medical Director, given previous concerns about MS, which were being considered by Dr Gray and Dr McConville. As Dr Craig was fully aware of the background to the original concerns of Dr Fitzpatrick, it is clear that the responsibility rested with him to escalate immediately. The Inquiry Panel also notes Dr Peukert's evidence that he was raising the matter with

Dr McDonnell as the Clinical Lead. Dr McDonnell did arrange for additional tests to be carried out, which took place on 5th June, by which time the Gray/McConville report had been received.

25th April 2017:

- 15.121 By 25th April, it had been decided by Dr Jack, following advice from the Association of British Neurologists, to contact the Royal College of Physicians (“RCP”) in London to enlist their help. This was because the RCP has the capability to carry out an authoritative review based on patient records, for a number of specialities. Mr Mitchelson informed Dr Jack that a pro forma would need to be sent and signed off by the Medical Director.

27th April 2017:

- 15.122 On 27th April 2017, an issue arose with a patient. Ms Lundy had noted from the Electronic Care Record that this was to be the patient’s third blood patch procedure and that, following her last procedure, she had required a 5-day admission. The patient had originally been referred to Dr Watt by Dr Raeburn Forbes, a Consultant Neurologist in Craigavon. Ms Lundy alerted Dr Craig that the patient had not been identified on Dr Peukert’s database. Dr Craig made it clear that the procedure could not proceed until and unless it had been approved by Dr Peukert.

3rd May 2017:

- 15.123 On 3rd May 2017, Nurse Chris McKee forwarded a draft Significant Event Audit (“SEA”) to Ms Lundy in respect of INI 399. The following aspects are of note:

Mr Watt had reviewed [INI 399] following a GP referral for; left sided headaches, right sided weakness, reduced mobility and memory problems in the week commencing 2nd January 2017. Mr Watt suspected intracranial hypotension as a result of cerebrospinal fluid leak following spinal surgery in July 2016. Mr Watt placed [INI 399] on a day case waiting list for a lumbar epidural blood patch ...

16th January [INI 399] is reviewed by Neurology consultant MW who requested an MRI scan. [INI 399] is also reviewed by another Neurology consultant TP who states that [INI 399] experiences constant headaches that worsen when he stands up and are relieved when lying down. Dr TP ... then documents not for blood patch at present.

...

20th January at 19:00 [INI 399] is reviewed by Neurology consultant TP, he makes him aware that his MRI is normal so his headache symptoms could be related to low pressure. However, this may be the wrong diagnosis and Dr TP explains the risk of a blood patch to [INI 399] and his wife. [INI 399] would like to proceed with the blood patch due to his poor quality of life.

...

23rd January – MW neurology consultant performs blood patch.

4th May 2017:

15.124 On 4th May, Ms Lundy emailed Mr Young as follows:

Hi Frank

As per conversation earlier, I have attached Dr Peukert's response to my request for information regarding the patient who had been booked for a CT guided epidural blood patch. We had no clarification regarding the appropriateness of this procedure, so [PATIENT] was contacted yesterday and the appointment for today was cancelled.

[PATIENT] has had two previous CT guided epidural blood patches (28/4/16 and 13/10/16). Thomas [Peukert] has not reviewed this patient's file and therefore is not in a position to confirm if an epidural blood patch is indicated.

Regards Clare

15.125 On the same date, Dr Mitchelson subsequently completed a Pro Forma Request for an Invited Service Review by the RCP and also emailed the Medical Director, Dr Jack, with a brief summary of the concerns to be included in an email to the RCP of 4th May. The concerns were summarised by Dr Mitchelson as follows:

Concerns were raised by one of our local GPs, who is also an NCAS advisor, concerning the practice of one of our Trust's Consultant Neurologists. The GP raised concerns about three cases initially (two around a potential diagnosis of MS, and one around a patient with a possible seizure disorder). Three further cases have subsequently been identified which relate to patients with a diagnosis of spontaneous intracranial hypotension and the use of blood patches. One of these cases was identified by the Clinical Director for Neurology, who therefore felt that it would be inappropriate for him to lead on any investigation. Two colleagues from a neighbouring Trust have been asked to provide independent reviews of these cases to ascertain whether the management, in their opinion was reasonable. They have apparently completed their reviews and we are awaiting their reports.

Whilst we await this report we audited the local prescription of epidural blood patches and it was found that there is striking variation in practice. In the last 5 years 254 have been performed in Belfast Health & Social Care Trust. Of these 231 were prescribed by the individual in question. The numbers appeared to be rising rapidly over the last couple of years.

The individual has been instructed not to prescribe, or recommend, blood patches until the process of investigation is complete. He has been informed that this applies to both NHS and private work. He has been instructed that should he feel that he has seen a patient with potential spontaneous intracranial hypotension, then this patient's records should be reviewed by a named consultant colleague. There has been disagreement over the majority of cases. This process has been made more challenging as the individual in question is the senior clinician in the service.

We have a number of concerns:

- The individual in question has adopted assessment, investigative and diagnostic practices that would not be in keeping with a body of his peers.
- That he is giving patients an incorrect diagnosis of spontaneous intracranial hypotension well beyond that expected with random error.
- That he has recommended and performed a procedure with the potential to cause harm.

It should be noted that at this time we have no evidence of any harm being caused.

7th May 2017:

15.126 On 7th May, Dr Jack emailed Mr Young, having viewed the earlier email chain about a patient who was not on Dr Peukert's list. In her email, Dr Jack stated:

It is clear that Michael [Watt] has not complied with the restriction regarding this case. I think he needs to be met and this case discussed with him and the reasons for non-compliance explored.

8th May 2017:

15.127 By the 8th May, Dr Peukert reviewed the notes of the patient referred to at paragraph 102 above. He did not approve the blood patch procedure and indicated he was *"not made aware at that time that there was any issue in relation to Dr Watt's compliance"*.

15th May 2017:

- 15.128 On 15th May, the Health & Social Care Board (“HSCB”) write to the Belfast Health & Social Care Trust (“BHSC”) asking whether the Trust intend to call an SAI in respect of ongoing investigations into concerns relating to Dr Watt.

16th May 2017:

- 15.129 On 16th May, BHSC reply, advising HSCB that they do not intend to call an SAI as, “To date, no issues of concern have been identified and it would not therefore be our intention to report this matter as an SAI at present”. Dr Jack has already addressed this in her evidence of 5th February 2020 cited at paragraph 107 above.

17th May 2017:

- 15.130 On 17th May, Mr Young having discussed the previous day with Dr Watt the issue of referral of a CT patient for a blood patch emailed Dr Mitchelson a draft note of the meeting inviting his comments. Dr Watt, had explained that the referrals were not self-referrals, but had been made by other neurologists.

Note of meeting with Dr M Watt – 16th May 2016

In attendance:

Frank Young, Co-Director

Mark Michelson, Chair of Division

Michael Watt, Consultant Neurologist

Issue of patient being referred for a CT Guided Blood Patch was discussed. Dr Watt state he is in full compliance with the restrictions current [sic] in place in retention [sic] to him undertaking blood patching procedures unless:

1. The request has been forward to Dr T Peukert for a clinical second opinion and approved by him.
2. That a blood patch procedure requested had been forwarded to Dr Watt by another Consultant Neurologist.

Dr Watt referred to the CT Guided Patient in question and stated that this was a repeat procedure (3rd patch) and that the request had been sent to him by Dr R Forbes.

Dr Watt asked in relation to a repeat patch where Dr Peukert had previously confirmed that the patient would be suitable for a Blood Patch procedure. Mr Young agreed to follow up and report back.

Mr Young raised the issues of blood patch referral continuing to be forwarded by Dr Watt to Dr Stephen Hunt who both work in private practice at the Ulster Independent Clinic. Since the meeting of 13th April Dr Watt confirmed he had not forwarded any further requests since the meeting and that these must be the remained old referrals continuing to trickle through. Dr Watt again confirmed that he was in full compliance with the restriction letter issued by the Medical Director on December 13th.

Dr Watt stated that he was very frustrated with the restriction process and felt that no other Neurologist or Neuroradiologist had his level of expertise and that he reminded [sic] best placed clinically to determine which patients would benefit from a blood patch procedure.

Mr Young offered Dr Watt an Occupational Health referral but this was robustly declined.

15.131 On the same day Mr Young then emailed Dr Jack on 17th May regarding the patient stating *“waiting on clarification on the requestor. Michael has stated these were from other Neurologist and not self-referrals. Will confirm as soon as I have clarification”*.

15.132 Mr Watson then referred Mr Young to the terms of the restriction and indicated *“I cannot see what difference it would make that the referrals from other Neurologists.”*

15.133 Subsequently, Mr Young messaged Ms Lundy and Mr Atkinson as follows:

Clare/Gerry

Medical Director looking for an update.

Can you get back to me asap to confirm who the CT guide Blood Patches were requested by.

Michael stated these were not self-referrals but from other neurologists – need this bottomed out.

Thanks Frank

18th May 2017:

15.134 On 18th May, Michelle Wong from the Royal College of Physicians (“RCP”) sent an email to Dr Jack following on from the teleconference of 5th May 2017, indicating that the RCP would await the outcome of the Gray/McConville investigation.

23rd May 2017:

15.135 On 23rd May 2017 Ms Lundy emailed Mr Young:

Blood patch information recorded below, as required. This includes information on 5 patients, including patient which states “original referral form” not clear from, the documentation. patient may have attended Dr Watt at Ulster Independent Clinic. Has had several blood patches.

15.136 In his evidence to the Inquiry Panel of 15th July 2021 Mr Young stated:

Michael Watt had given assurances that the patients, including [patient] had been referred by other Consultant Neurologist. In hindsight this should have been verified to ensure this was actually the case. Had this been done then a potential breach of Dr Watt’s restrictions could have been identified at this time.

15.137 Mr Young had, in fact, asked Ms Lundy to verify Dr Watt’s earlier statement that other patients had been referred by another neurologist, but she had been unable to do so, despite inquiries. This was a matter which should have been queried further at the time rather than simply accepting Dr Watt’s assurance especially given the ambiguity in the information obtained by Ms Lundy.

24th May 2017:

15.138 On 24th May, Nurse Chris McKee emailed Ms Lundy a further draft of the SEA relating to INI 399 indicating: *“I have made the changes we agreed on Monday.”* In this draft, the reference to potential incorrect diagnosis had been removed, as previously suggested by Dr McDonnell. The new draft read:

20th January 2017 at 19:00 [INI 399] is reviewed by Neurology consultant TP, he makes him aware that his MRI is normal so his headache symptoms could be related to low pressure. Dr TP explains the risks of a blood patch to [INI 399’s] wife and [INI 399] would like to proceed.

30th May 2017:

15.139 On 30th May, Mr Watson emailed Dr Jack (who had not been in work full time as she was caring for her father who was gravely ill) confirming the earlier understanding that *“where the diagnosis and treatment plan has been made by another neurologist then Michael can proceed with the patching procedure”*. Responding to this, the Medical Director stated on 30th May:

Dear Peter,

I am responding given the email trail below. I have not been party to any recent discussion.

Thank you for the below. There is no concern about Dr Watt's technical ability to perform the procedure, nor are there concerns about any other neurologists and their use of the diagnostic criteria.

The information I received below was that Michael had been the diagnosing consultant for the case he had subsequently referred. If this was another consultant and Thomas now believes that the diagnostic criteria was not met then I think that we now need to establish if John has any concerns about other colleagues regarding diagnosis.

Kind regards

Cathy

1st June 2017:

- 15.140 On 1st June, Mr Young received reports from Dr Gray and Dr McConville.
- 15.141 Dr McConville's report raised concerns in respect of five out of the six index cases. Dr Gray's report raised concerns in four cases and had questions in relation to the same fifth case. The findings are summarised below:

Dr McConville:

File No.	Conclusions
Index Case 1 It was reasonable to consider a diagnosis of multiple sclerosis based on the history given. She was appropriately investigated ... a suitable diagnostic process was followed ... the final diagnosis was not reasonable. The symptoms ... are not specific. Apart from the ophthalmology question of optic disc pallor, I could not see any documented physical signs. She had multiple negative tests many of which have high sensitivity for MS ... this presentation falls well short of diagnostic criteria for MS ... there is evidence of review ... but a persistent assertion that relapsing-remitting multiple sclerosis was the most likely explanation for her presentation. This person was commenced on Copaxone ... this would not be justified on the basis that the diagnosis had not been adequately established.

File No.	Conclusions
Index Case 2	<p>a reasonable diagnostic process was followed at least initially ... MS was a not unreasonable working diagnosis but I would not have crossed a clear diagnostic threshold without further diagnostic tests ... The diagnosis given is a qualified diagnosis i.e. “MS would be the most likely explanation” ... I don’t see evidence of diagnosis being reconsidered. She had some courses of high dose corticosteroid depending upon her active symptoms. These could plausibly have been justified on the basis of a working diagnosis of MS while investigations were ongoing.</p>
Index Case 3	<p>There is evidence of detailed history taking. There is also a reported examination finding ... an MRI scan of brain ... showed no abnormalities. I would consider this an appropriate investigation ... it is reasonable to consider a brainstem episode despite a normal MRI scan ... The diagnosis was a qualified diagnosis i.e. “I continue to feel his problems are due to an inflammatory brainstem illness”. It is clear that despite the normal MRI scan of brain ... this has been taken into account. There is evidence of a referral to neuropsychology ... There is no further comment on the presence or absence of any brainstem sign. There were further tests looking for corroborating evidence for disorders like MS ... Approximately 5 years from presentation the question of spontaneous intracranial hypotension as a possibility is raised ... This was appropriately investigated ... this review of his diagnoses and investigations [were] appropriate ... I cannot see evidence of him being referred for a blood patch. He was treated as migraine ultimately.</p>
Index Case 4	<p>There was evidence of detailed history taking ... the MRI scan of the brain showed no abnormality ... investigation with imaging I would consider appropriate ... The final proposed diagnosis was ... spontaneous intracranial hypotension. I don’t feel the history as presented is suspicious of intracranial hypotension ... there was nothing on her MRI scan ... documented in ... Notes which would be supportive of that diagnosis. I would not consider spontaneous intracranial hypotension a reasonable diagnosis ... There is evidence of the diagnosis being reviewed ... then a consideration that the headache might be due to high pressure with commencement of Acetazolamide ... I would not have made a diagnosis of a headache on the basis of a high pressure state on the basis of this MRI finding alone. The history and MRI as presented are not ... indicative of low pressure state as a likely cause and ... I would not have thought it clinically appropriate or reasonable to proceed to blood patch ...</p>

File No.	Conclusions
Index Case 5	<p>... The imaging ... did not reveal supportive evidence of intracranial hypotension ... a reasonably appropriate diagnostic process was followed ... the diagnostic threshold for spontaneous intracranial hypotension or low pressure headache would not have been passed by the information provided. I would have considered low pressure headache unlikely ... additional supportive evidence of a low pressure state would be necessary to make a diagnosis, for example direct measurement of pressure ... I would not have proceeded to blood patch on the basis of the information presented. I would consider it inappropriate.</p>
Index Case 6	<p>This man presented with a collapse ... I would consider the diagnostic process suitable. The history ... is of an unclassified collapse with seizure markers. There is evidence ... of the differential diagnosis consideration ... At review, just over 2 weeks later, there is comment upon headache with migraine features ... and the likely diagnosis was of a fall, injury to the head and a reflex seizure as a consequence. He was considered fit to continue driving ... the possibility of an epileptic seizure could not have been excluded at this point and would have impacted upon his driving ... This man went on to have further events ... There was evidence of detailed repeat history taking ... There is a diagnosis of migraine with aura for which treatment was recommended. Subsequent events are interpreted as uncertain ... the nature of episode “remains somewhat uncertain’ – “best viewed as migraine and a faint”. There is clear evidence of consideration of various differential diagnoses. This type of diagnosis ... carries intrinsic uncertainty ... the history given was suspicious of localisation related focal epilepsy as a cause but I would consider this diagnostic process intrinsically subjective.</p>

Dr Gray:

File No.	Conclusions
Index Case 1	<p>... A diagnosis of recurrent episode of inflammatory demyelination was made ... There is no documentation of a neurological examination ... It is appropriate to consider a diagnosis of inflammatory demyelination and to investigate for this. There is however a suggestion of a significant life stressor in the past, a possible panic attack and anxiety. Patient was reviewed ... At this stage all investigations ... were normal ... A diagnosis of inflammatory demyelination was made despite these normal investigations ... the diagnosis of possible inflammatory demyelination is documented. She was given a course of steroids. There is documentation of low mood. Patient then presents with vertiginous symptoms, visual blurring with a note of "a stressful summer". Vitamin D levels were checked and MRI scan ... was repeated and was normal. She was reviewed on a number of occasions ... An MRI scan was repeated ... This identified a solitary non specific lesion in the left temporal lobe but no other abnormalities. She was given a diagnosis of relapsing-remitting multiple sclerosis and commenced on disease modifying treatments. She has represented over the years with multiple symptoms ... There is no objective evidence that this lady has relapsing-remitting multiple sclerosis. I would not have made this diagnosis nor treated with corticosteroids and would not have commenced disease modifying treatment. I highly suspect that this lady has a non structural neurological illness secondary to previous life stressors.</p>
Index Case 2	<p>... There is no mention in the clinic letter from the Ulster Independent Clinic with regards to a neurological examination. A diagnosis of multiple sclerosis was felt to be most likely. She was commenced on oral Methylprednisolone. She subsequently had an MRI ... this did show multiple white matter lesions. The report comments that they may represent inflammatory demyelination but specifically these could be ischaemic or incidental ... This lady represented ... She had had significant side effects from Prednisolone ... She was diagnosed with a further relapse and given a course of oral Dexamethasone. She was seen again ... and had documented side effects to the Prednisolone again. When first assessed the differential ... would have been inflammatory demyelination or chronic small vessel ischaemia. Without documentation of any neurological examination it is difficult to discriminate between the two ... I would not have commenced oral Methylprednisolone at this point in time. I would have awaited imaging. This lady's imaging is non-specific ... I would have investigated further ...</p>

File No.	Conclusions
Index Case 3	<p>... Provisional diagnosis of brainstem inflammation was made ... an appropriate diagnosis ... however there would still be a differential at this stage. This gentleman returned ... with new symptoms ... He was treated with oral Methylprednisolone and transferred to the NHS for ongoing care. He was assessed again ... by which stage he also had a reducing course of oral Dexamethasone. It was noted that it made most of his symptoms better although his balance was worse. Other investigations ... were requested ... This gentleman clearly did need further investigations and inflammatory disease of the CNS was still very possible. My approach would have been to await the results of investigations before considering treatment with steroids. However, it was not unreasonable to treat with steroids. This gentleman was admitted to ... hospital with a number of symptoms including unsteadiness which was episodic ... he was in hospital for 3 days. He did not have any specific investigations during this time. He was commenced on an anticonvulsant drug Carbamazepine (Tegretol) ... a drug that can be used for epilepsy, migraine or pain. This gentleman attends ... on a number of occasions with "attacks". During this time he changes from Carbamazepine (Tegretol) to Sodium Valproate (Epilim), Levetiracetam (Keppra), Lamotrigine (Lamictal), Gabapentin and Zonisamide (Zonegran). He also had repeat imaging of his MRI ... It is entirely appropriate to re-image this gentleman to investigate for a structural cause for his symptoms. It is not clear to me as to what the working diagnosis is, though he is treated with six anticonvulsants. If the diagnosis was epilepsy, I would expect the patient to be counselled regarding this and given information regarding medications, safety and driving. There is no documentation regarding driving. On review of the notes, I suspect this patient has a non-structural neurological or functional disorder.</p>
Index Case 4	<p>... There was a postural component to the headache ... MRI scan ... showed no abnormality. A diagnosis of spontaneous intracranial hypotension was made and she was referred for epidural blood patch. She proceeded to have 2 epidural blood patches. There was no improvement in the headache with the blood patches and her symptoms had worsened. MRI ... showed the pituitary fossa partially fluid filled. It was otherwise normal. A diagnosis of high pressure secondary to epidural blood patches was made and it was recommended that Acetazolamide was commenced. When this lady initially presented there was no objective evidence of a low pressure headache. I would not have considered an epidural blood patch in this case ...</p>

File No.	Conclusions
Index Case 5	<p>... She had a road traffic accident ... with a headache. It was initially relieved by lying as well as a number of other abnormal symptoms ... There is no documentation of a neurological examination. MRI scan ... showed no significant abnormality. A diagnosis of intracranial hypotension was made, perhaps due to a dural tear during her road traffic accident. There is no objective evidence of intracranial hypotension here. The headache does have a postural component. There are multiple other symptoms which would be highly suggestive of anxiety related symptoms. In my opinion, an epidural blood patch was not appropriate at this point.</p>
Index Case 6	<p>... The differential diagnosis of a fall leading to head injury and seizure or seizure resulting in fall in a head injury is entirely appropriate. He proceeded to have an MRI scan of brain and EEG which are again appropriate investigations. At review it was noted that his investigations were normal and he had no further episodes. A diagnosis of migraine causing headache and visual disturbance with episode of loss of consciousness was diagnosed as a fall with a head injury with reflex seizure. The initial differential diagnosis is entirely appropriate and the patient was investigated appropriately. It is unclear from the notes why a definitive diagnosis was made at review. This would have been a decision made on review of the history and this could be entirely appropriate. From the information available to me, I would not be able to make a definitive diagnosis. He represented ... with another episode ... losing consciousness and stiffening. On coming round he had a second episode that "looked more like a seizure". A diagnosis of reflex anoxic seizure was made. I agree that the preceding symptoms and being held in an upright position reflex anoxic seizure is more likely than an unprovoked seizure. He represented ... with a headache. A diagnosis of migraine was made and I agree with this diagnosis. He represented ... having had another episode ... Dr X has made a diagnosis of a migraine and a faint. Dr X has clearly taken a comprehensive history of the episode. It is very difficult to be definitive in this case. The history ... could fit with this gentleman's migraine and a fainting episode. A thorough history has been gained in this case and is the key to any diagnosis after an episode of loss of consciousness. There is no documentation of a neurological examination available to me. The reason for the initial definitive diagnosis is unclear from the documentation, however this decision would have been made on review of the history alone and history taking has been thorough here.</p>

6th June 2017:

15.142 Having received the reports, a meeting was arranged on 6th June in Mrs Owens' office with Professor Ian Young, (then Deputy Medical Director in the Belfast Trust) Dr Mitchelson, Dr Craig and Dr McDonnell in attendance. Dr Jack was not in attendance following the death of her father. Prior to the meeting, in an email of 5th June, Mr Watson set out the immediate key questions:

1. Do the reports now received require a review of the restrictions currently in place, in order to ensure the safety of patients and staff?
2. If yes, what restrictions would need to be put in place to ensure the safety of patients and staff?
3. How could any such restrictions be put in place – are they workable?
4. Thereafter we will need to consider if and how further review of the current and previous practice of the Consultant is indicated.
5. We will also need to carefully consider the implications for the service moving forward, and any required communications etc.

15.143 Mr Watson then also drew up a detailed note of the meeting that took place on 6th June. The salient points of that note are listed below:

- It was agreed by Drs Craig and McDonnell that two of the cases raised concern in relation to the diagnosis and treatment of intracranial hypotension. It was further noted that the current restrictions in place ensured the safety of patients and staff in relation to this aspect of Neurological practice.
- It was agreed by Dr Craig and McDonnell that two of the cases raised concern in relation to the diagnosis and treatment of MS. While it was noted that there were some departmental audits principally in relation to treatment of MS, it was agreed that these new concerns required there to be a review of the restrictions currently in place, with additional restrictions required where diagnosis and treatment of MS was being considered.
- It was agreed that restrictions in other aspects of Neurological practice were not indicated, in the context of no other particular or specific concerns at this time. This position to be kept under review.
- It was agreed that Dr Watt would be required to discuss and agree any new diagnoses of MS, or treatment changes for those already diagnosed with MS, with a Consultant Neurologist with a subspecialty interest in MS.

- Dr McDonnell and Dr Craig highlighted the service pressures which would arise from such additional work, but agreed that they would seek to come up with workable proposals to facilitate such supervision.
- It was agreed that there would need to be a review of the current and previous caseload of Dr Watt. Dr Craig advised that he anticipated that Dr Watt currently had circa 2000 patients under NHS review, with circa 400 receiving DMTs, and circa 80 of these on 2nd line MS drug treatments.

15.144 Also on this date, Ms Nicky Vincent, Governance Manager for Neurosciences emailed Ms Lundy with regard to the INI 399 SEA, requesting a meeting and stating: *“this report is still not right”*.

7th June 2017:

15.145 Dr Craig confirmed on 7th June that Dr McDonnell had agreed to provide an initial point of contact for review of new MS diagnoses by Dr Watt and existing cases where additional medication was being considered.

15.146 On the same day, Dr Mitchelson wrote to Dr Watt inviting him to a meeting with Mrs Owens and himself to discuss the findings of the review and advise him as to the future course of action.

15.147 Also on 7th June, Mr Watson forwarded a draft letter, addressed to Dr Watt, to Steve Boyle (NCAS) for review. The letter indicated that Dr Watt’s *“practice in relation to the diagnosis and treatment of MS also be subject to supervision”*. Mr Boyle’s reply on 7th June noted that Mr Watson’s letter was clear and self-explanatory and suggested that a timescale for the restrictions may be appropriate. Dr Craig replied:

We will need to consider how to undertake review of those cases on second line agents (94 prevalent cases, with additional number on waiting list for alemtuzumab). In regard to cases identified by GP, one has been seen by two other neurologists (Dr Stephen Hunt and me and has management plan in place and has no further reviews with Dr Watt).

8th June 2017:

15.148 A further meeting of the Trust Board takes place but there is no mention of the issues arising in neurology in the Confidential Board Minutes.

9th June 2017:

15.149 On 9th June, Mr Boyle sent a letter summarising NCAS advice to Mr Watson. Salient extracts are set out below:

This case is about [Dr Watt], a consultant neurologist where concerns about his clinical practice have been discussed with my NCAS colleagues and are referred to in earlier correspondence.

You have contacted NCAS to discuss the external review by two Consultant Neurologists of six patients treated by [Dr Watt] ... We spoke before a meeting planned to discuss the next steps in the case where the reports will be considered and to review the current restrictions in the practice of Dr Watt and decide if they need to be varied or extended. In addition, the process of implementing any varied restrictions and to consider the next steps in the case. Following the meeting, you updated me that the two cases of intracranial hypotension raised concerns related to diagnosis and treatment. It was agreed that the current restrictions in place ensured patient safety. Following a review of the two cases regarding the diagnosis and treatment of Multiple Sclerosis (MS) there were concerns identified and restrictions on the practice of [Dr Watt] would be considered. It was also agreed to review the current and previous caseload of [Dr Watt].

... I advised that the approach taken by the Trust is in line with the guidance in the national framework 'Maintaining High Professional Standards in the Modern HPSS'. As the next steps may involve a formal investigation of the identified concerns it would be good practice to seek a response from Dr Watt as part of the initial assessment process.

15.150 At the meeting on 9th June, Dr Mitchelson gave Dr Watt a letter, which had been drafted by Mr Watson and signed by Professor Young. The letter outlined additional restrictions. The relevant paragraphs are set out below:

I am required by MHPS to consider if there is any immediate risk to patient safety by your continuing in all aspects of your current clinical role. I have taken the view that there are concerns in relation to your diagnosis and treatment of intracranial hypotension, and that there are concerns in relation to your diagnosis and treatment of MS. I have then considered the action appropriate to manage these concerns.

I have determined that it is now appropriate that your practice in relation to the diagnosis and treatment of MS also be subject to supervision. I have therefore asked that your Clinical Director and Clinical Lead seek to make arrangements so that any new diagnosis of MS or treatment changes from first line to second line therapies should firstly be discussed with a named Consultant Neurologist,

with such discussions recorded in the patient notes. Dr Craig will in due course confirm the arrangements to facilitate this.

I would ask for your express confirmation that you will comply with the arrangements.

15.151 Following the meeting on 9th June, Dr Mitchelson drew up a detailed minute. The salient paragraphs were as follows:

Bernie [Owens] and I met with Michael Watt this afternoon at 14.00 hours in my office. He had chosen not to bring a companion to this meeting despite strong advice to the contrary. He was again offered this opportunity but stated that it was “not my way”.

I explained that as concerns had been raised around his clinical practice we had a duty to consider these under the framework of Maintaining High Professional Standards in the Modern HPSS (MHPS). It was felt necessary to place further restrictions on his practice in relation to his diagnosis and management of MS. This would involve discussing each new patient with a potential diagnosis of MS, or any patient with a current diagnosis of MS thought to need escalation of treatment to include DMT. Michael was informed that Gavin McDonnell has agreed to perform this role. Michael indicated that he felt this was acceptable and he could work with this.

Michael volunteered that he felt that his workload was pressurised and possibly out of control. He also stated that he felt isolated. He noted that he was not part of a team in terms of his ward rounds (previous colleagues no longer practising), and that in his clinics (bar the TIA clinic which he felt worked well), he was again the sole consultant. He made the following suggestions:-

- That another consultant, or team, practiced alongside him in clinics.
- That he was integrated into a ward team.

Michael voluntarily admitted that he “pushed the boundaries” of practice but did so in good faith. He admitted that he was sometimes quicker to make diagnoses than peers and more aggressive in starting treatments. He felt that colleagues were maybe too conservative and that he had concerns that delays in treatment had the potential to cause harm. He stated that in terms of DMT for MS there had previously been discussion of a “DMT Committee” to make decisions on who should start such treatments but that he had not been keen due his feeling that colleagues were too conservative and that there may be unnecessary delays in administration. He stated that he was now open to such a possibility and I undertook to discuss with John Craig and Gavin McDonnell.

12th June 2017:

- 15.152 On 12th June, the Belfast Trust shared concerns regarding an anonymous doctor [Dr Watt] with the GMC representative in Northern Ireland, Joanne Donnelly. The email enclosed a redacted letter of restriction to Dr Watt and copies of the Gray/McConville reports and asked that the GMC Employer Liaison Adviser review the details so that there could be a discussion as to whether a referral to the GMC was indicated at that point in time. On the same date Dr Jack also engaged with the Royal College Physicians (“RCP”) and explained that a meeting had taken place to agree the next steps to be taken, and that the Belfast Trust would be in touch with the RCP thereafter.

13th June 2017:

- 15.153 On 13th June, Ms Donnelly sought clarification that the restrictions extended to private sector practice. Mr Watson from the Medical Director’s Office replied on the same day stating:

The conversation with the doctor and the letter he received confirms the need for the restrictions to apply in the private sector also.

- 15.154 On the same day Mr Watson emailed Dr Watt asking him to confirm his compliance with the arrangements in the letter.

14th June 2017:

- 15.155 On 14th June, Ms Lundy emailed Mr Atkinson in respect of the ongoing investigation concerning INI 399 indicating: *“This is not an SEA/SAI. It was a review of clinical notes to establish facts!”* The Inquiry notes that the draft of 26th May 2017 was entitled ‘Level One – Significant Event Audit Report Guidance, with ‘date of significant event’ and ‘SEA facilitator/lead officer’ completed. However, the draft of 8th June 2017 was entitled ‘Clinical Review following receipt of a complaint and now refers to ‘date of incident’ and ‘facilitator/lead officer’.

- 15.156 On the same day, Mr Watson wrote to Dr Craig regarding a phone call received from Dr Donagh MacDonagh, a GP at Dunluce Health Centre and previously Associate Medical Director for General Practice within the Belfast Trust. Dr MacDonagh had been given a private script for Sativex prescribed by Dr Watt to assist a patient to give up smoking. Dr MacDonagh suggested that this appeared unusual, and it might be prudent to have the matter reviewed.

15.157 Further, on 14th June, Ms Donnelly the GMC Employer Liaison Adviser wrote to Professor Young indicating that she would await the outcome of the MHPS investigation before advising as to whether threshold for referral to the GMC had been met. She also indicated that asking Dr Watt to inform the private sector organisations in which he worked about his restrictions, was insufficient.

15th June 2017:

15.158 On 15th June, Dr Watt confirmed in writing to Dr Craig that he understood that the restrictions in respect of both SIH and MS applied to the private sector.

15.159 A further meeting then took place on 15th June with Dr Jack, (who had recently been off work following a family bereavement,) and was attended by Mrs Owens, Dr Mitchelson, Dr Craig and Mr Watson. Dr Jack was given a full update on the Gray and McConville reports. She had wished to confirm with both doctors as to whether the test, diagnosis and treatment had been inside or outside a reasonable range of practice. The Inquiry has been provided with an annotated copy of the agenda for this meeting. The main points from the Minutes are set out below:

The restrictions in relation to MS and Intracranial Hypotension patients were noted and considered satisfactory at this time pending further updates.

It was noted that a concern had been raised from another GP and regarding the prescribing of Sativex. Dr Mitchelson to seek further details from Pharmacy in relation to this concern.

Dr Jack reported concern that Dr Watt may have been referring patients who he thought had intracranial hypotension outwith NI. It was agreed that Dr Craig should clarify with Dr Watt the need for all such potential diagnoses to be discussed with Dr Peukert.

Collation of records in relation to practice concerns – Mr Watson noted that in addition to a comms file for each and every patient who was the subject of concern or review, there would need to be a process of capturing concerns in relation to Dr Watt's practice, and any review of these. Mrs Owens agreed to identify a member of staff who would lead on this and would contact Mr Watson to progress.

ACTION: Mrs Owens.

? Case note review / Lookback of previous patients – it was noted that there were circa 250 patients who had been added to the waiting list for blood patching over recent years, with circa 120 of this 250, currently waiting for patching.

New patient management – It was agreed that the arrangements in place were satisfactory, although it was agreed that there should be additional clarity to Dr Watt that any initiation of first line treatment with DMTs should also be the subject of approval in advance with Dr McDonnell subject of approval in advance with Dr McDonnell.

16th June 2017:

15.160 On 16th June, Dr Craig emailed Mr Watson, having spoken to Dr McDonnell in regard to the initial case note review with patients with MS who were on second line Disease Modifying Treatments (“DMT”s). Dr McDonnell had agreed to take on this work and he had to take a few days from his working schedule to complete the task, even though that would mean cancelling clinical commitments.

15.161 Commenting on the approach taken, Dr Craig, stated in his evidence of 6th February 2020:

We didn’t go looking immediately for every MS case because we knew he had so many. We looked at those that were going to be starting on new diagnoses. Those that were moving from first line to second line. We didn’t immediately say, ‘let’s just stop all’. So even when the MS restrictions came in, they weren’t complete restrictions on MS practice.

15.162 Dr Craig also gave evidence about the operation of the new MS restrictions:

From memory, it was again very much done on trust that Michael would come and speak to Gavin [McDonnell] about those cases. In reality, I mean, certainly I have no information that I can show you, a table or list of cases where that happened or didn’t happen. I think in terms of when you introduce this, how you actually follow up on it and make sure it is being done, I am not sure it can be left to the respective clinician who is doing his own. He will deal with it as it is brought to him, but somebody needs to be making a record of it and following up on it.

15.163 Asked about the rationale for the partial restriction, Dr Craig stated:

The second line drugs is maybe slightly easier because they are the ones that carry the highest risk. The first line therapies for multiple sclerosis would be the interferons and copaxone, so pretty safe drugs. Whereas the second line drugs are not necessarily. ... you could ask yourself at this point in time why we didn’t restrict all MS practice. We were not saying he couldn’t see patients with MS because certainly at the time of diagnosis you don’t know they have it until you have done the tests and the investigations. We were just saying in terms of the therapeutic decisions, and the risks seems to be highest for new diagnosis and

the second line drugs. But it still begs the question what about all the patients who are already on these first line drugs who maybe don't need to be on. So there is a deficiency in that argument. Again knowing what we know now in terms of diagnostic accuracy rates, there was a bigger discrepancy for those that seemed to be on the safer drugs than those who were on the high end drugs. It's when trying to make a decision that made who you would have felt were those at the highest risk, there was actually a group left behind who, counter intuitively or otherwise, were failed by the process.

19th June 2017:

- 15.164 On 19th June, Mr Watson emailed Dr Watt to inform him that he had not received written confirmation from the independent sector organisations that the correspondence regarding the restrictions had been shared with them.
- 15.165 A further meeting regarding Dr Watt took place on 19th June, attended by Dr Jack, Mrs Owens, Dr Mitchelson, Mr Young, Dr Craig and Mr Watson. In relation to the Sativex prescription, (see paragraph 155 above), Dr Mitchelson advised that Eimear McCusker, Pharmacy Manager at the Belfast Trust did not consider there was a legal issue with the prescribing of controlled drugs per se, provided there was clinical justification. Concern remained, however, because of the stated reason for prescribing of the drug. Dr Mitchelson confirmed that, at some point, Dr Watt would need to be asked why he had prescribed Sativex without discussion with the patient's GP. Dr McConville joined the meeting by telephone in relation to the diagnosis and subsequent treatment of one of the 6 index patients. Dr McConville, however, did not have the notes with him and was reluctant to make statements in areas which may need to be nuanced and clarified.

20th June 2017:

On 20th June, Dr Mitchelson confirmed to the Medical Director, following advice from pharmacy colleagues, that no other practitioners in Northern Ireland were prescribing Sativex for smoking cessation. Dr Jack indicated that she would need to consider the next steps. As a result of further discussion, Dr Jack then decided that it was appropriate, in the circumstances, to restrict Dr Watt from all clinical duties.

22nd June 2017:

15.166 Mr Watson subsequently prepared a draft letter outlining total restrictions on clinical practice. The concerns highlighted in the correspondence of 22nd June were in relation to the following matters:

1. I note that concerns were raised in relation to your diagnosis and treatment of intracranial hypotension, and restrictions had been put in place with effect from 16 December 2016.
2. I note that concerns were raised in relation to your diagnosis and treatment of patients with MS. Restrictions were put in place in relation to these, with effect from 9 June 2017.
3. I have been advised that having diagnosed a patient with MS in the private sector, you then added them to the NHS waiting list for treatment on 14 June 2017. I am advised that you had not spoken with Dr McDonnell in relation to this, despite the restrictions put in place on 9 June 2017. Therefore I have concern in relation to your fully complying with the spirit of the restrictions in place.
4. I have also been advised about one patient in which you have prescribed Sativex for smoking cessation. I am informed that smoking cessation is not considered a current indication for prescribing this drug, and that there is no record of any other patient in Northern Ireland being prescribed this for smoking cessation. I am also unaware of the patient being appropriately referred to the smoking cessation team. I am therefore concerned in relation to your prescribing practice, and also in relation to your not referring the patient to the appropriate experts.
5. I note the apparent tardiness of communication between yourself and the private sector hospitals in which you practice, and indeed to date I have not heard from the Medical Directors of either institution, despite the specific request made on 9 June 2017, and repeated subsequently.
6. I understand that when you met with Mrs Owens and Dr Mitchelson you indicated that you felt your workload was “pressurised and possibly out of control”, that you felt “isolated”, and that you “pushed the boundaries of good practice”. I understand that Dr Mitchelson arranged for you to be seen by the Trust Occupational Health Service, and I await a report from that consultation.

15.167 Mr Young and Dr Mitchelson were asked to give the letter to Dr Watt at a planned meeting with Dr Watt, which took place on 23rd June.

23rd June 2017:

15.168 Despite being asked to give Dr Watt the letter imposing clinical restrictions, Dr Mitchelson and Mr Young decided not to give him the letter at that time. In evidence to the Inquiry Panel, Dr Mitchelson explained that, having read the letter, he noted a paragraph, which stated as follows:

I have asked that Dr Mitchelson and Mr Young meet with you today and in the event that they cannot obtain a satisfactory explanation and assurance from you regarding the above concerns to share this letter with you.

15.169 Dr Mitchelson explained, when he gave evidence to the Inquiry Panel that there was some confusion as to which patient had, in fact, been prescribed the drug. In his evidence of 22nd October 2020, he was specifically asked about the instructions both he and Mr Young had been given:

Dr Mitchelson: Yes. So when we went into him, we did address the concerns that were raised there, and he gave us a justification for that. I didn't know whether they were right or wrong, but the letter and the rationale for the restrictions wasn't factually accurate if those could be disproved, and I wasn't the person who was writing the letter nor the decision maker, so he had given me and Frank a reason to counter that argument.

Mr Lockhart QC: But the impression we got from the evidence we have received, Cathy Jack and others, is: no, the decision had been made.

Dr Mitchelson: That wasn't the impression we were given. The expectation was that he was going to be restricted, I think, but it wasn't an absolute and he gave us reasons why I think, the drivers on that particular occasion actually might not be accurate. Again, it comes back to all these things; there are lots and lots of bits that have stacked up over a period of time, and at some point a decision needed to be made to go to a full restriction. If this was the moment where a decision had been made that there was enough uncertainty that there needed to be a full restriction regardless, then that's fine. But write that and that would be a different approach because we would be going in saying, 'unfortunately, Michael, we are restricting you. There are a number of things we are going to work through. We are going to support you'.

... That was not what we had there, that wasn't the process as we understood it.

Mr Lockhart QC: Where did you get that understanding from? Was it reading the letter or was it discussing it with Peter Watson or whoever?

Dr Mitchelson: I suspect more of it was through the reading of the letter, but there may have been informal bits in terms of conversation. We weren't sat down and said, 'you are going into the room to make sure this guy is not practising any more' ...

Mr Lockhart QC: I have to put this you, because it happened two days ago. Bernie Owens is saying well, you know, they just copped out of it. That was her view.

Dr Mitchelson: I am not an employment lawyer. I have no training in employment law. Did we have concerns about Michael? Were those concerns growing all the time? Did I think it was likely that he would be restricted? Yes. Was I the ultimate decision maker in that process? No. I'm not quite sure where I would have stood legally about giving him that letter knowing that he had given us, on the face of it, a reasonable reason to counter the claims within it. Coming back to something else we said earlier in the day, what is my priority there? It is ensuring that we are trying to protect patient safety. So we did ascertain that he wasn't working clinically, that he was away at a course. We then ensured there was a process of investigating these claims, that an action could be taking in advance of him seeing further patients. It wasn't that it wasn't necessarily going to happen but we didn't feel at the time we could give him that letter based on the instructions we had been given, the content of the letter, and what he said to us.

15.170 At 14:46 on 23rd June 2017, Mr Watson emailed himself the following note:

Sativex – he [Dr Watt] says was for pain relief and not smoking cessation. [Mark Mitchelson] did not have letter on him. Private patient – he says he was going to d/w GMcD [Gavin McDonnell]. No challenge re Med Dir correspondence. Annoyed re being asked to Headmaster office.

15.171 By 28th June, Dr Watt emailed Mr Watson stating:

I can confirm that I have cancelled all private clinics up to the 14th of July. Also, I have recalled why there is no mention of [Patient] smoking cannabis for her pain in either the notes or my letter – she asked me not to write it down for fear the notes might somehow fall into the hands of the police. Finally, I think I was shown the other Sativex patients notes at my meeting with Mark [Mitchelson] and Frank [Young] last Friday, which rather confused matters.

15.172 Mr Young also gave evidence about the decision not to give the letter to Dr Watt on 16th May 2019:

It was because of the concerns, and he gave us reasonable answers to those concerns. And, also, one of the other factors – if I remember this correctly, he was on leave and he wasn't clinical. So, he wasn't going to pose a risk in terms of --. We would've been --. He wasn't performing any clinical activity. So, we did have sufficient time to get more data information around the queries to go back to the Medical Director and say "This is what we've gleaned. This is what we've been told. Are you satisfied, or are you still not assured and do we

need to then formally do this? ... my memory of that would be that he gave us sufficient information that we felt we couldn't suspend him at that time.

15.173 Dr Jack immediately, on discovering that the letter had not been delivered by Dr Mitchelson and Mr Young, asked for an accurate note of the meeting with Dr Watt to be drawn up *"to better understand the reasons influencing your decisions and the information around the next steps"*. The note was prepared that evening by Dr Mitchelson. In addition to the concerns outlined above in the letter, Dr Mitchelson raised the question of Dr Watt's prescription of the drug Sativex for one of his patients. Dr Watt explained, when this was raised with him, that the patient in question had been seeing Dr Gerry Brown from the Pain Service and that Dr Brown had suggested that Sativex may be useful for the patient's pain. He felt that for a combination of pain and spasticity associated with the patient's pathology that Sativex might be useful. Dr Mitchelson further noted:

Michael suggested that any communication might have been misinterpreted. He suggested that as the drug cost £375 it was possible that the patient may have suggested to the GP that the prescription was for smoking cessation in order to try and avoid having to pay the private prescription costs.

15.174 The second issue raised by Dr Mitchelson with Dr Watt was in relation to a patient who had been added to the waiting list for Disease Modifying Treatment ("DMT") after Dr Watt had agreed to discuss patients with a new diagnosis of MS with Dr McDonnell. Dr Watt stated that he was not ignoring the restrictions and it was his intention to run this case by Dr McDonnell before the prescription for DMTs would be written. The note from Dr Mitchelson, which was forwarded to Dr Jack on 26th June 2017, further records a summary of the points made by Dr Watt:

He stated that he had a strong work ethic, a desire to try and help patients and an understanding that he may be the most able to deal with certain pathologies. This drove him to try and care for as many patients as possible. Michael stated that his clinics were very busy. He stated that he felt that they were too big but accepted that this was his doing for the previously stated reasons. He recognised that this was not sustainable and needed to be resolved. He indicated that he was making so many decisions that it was inevitable that he might make mistakes.

I stated to Michael that in addition to the aforementioned issues that it was recognised that his appraisal was outstanding. He stated that he was so busy with work that it would probably be August before he could get this completed. We again indicated that this was a matter of urgency and reminded him of the need for balance in his clinical practice. We stated that his practice needed to be safe and sustainable and that if he was "broken" and unable to practice then he would not be assisting those patients that might benefit from his services.

24th June 2017:

- 15.175 Dr Mitchelson expanded on his reasons for not giving Dr Watt the letter in an email to Dr Jack of 24th June:

Cathy,

I've sent the minutes to Frank to double check but as soon as I get word from him I'll forward to you. I am worried about Michael and whilst we didn't feel we could hand him the letter with what he said and the further questions that need dealt with, I feel that I have ongoing concerns regarding his practice.

He is away at a conference until the end of the week which will allow time to clarify the few outstanding issues and to tweak the letter to reflect these. My expectation is that he will be given this letter and a full clinical practice restriction is reasonable.

Happy to discuss at any point.

Mark

- 15.176 The issue of why the letter was not handed over to Dr Watt on 23rd June was explored by the Inquiry Panel. Dr Jack, in her evidence on 21st October 2020, was clear that she expected the letter to be given to Dr Watt. Dr Michelson, in oral evidence on 31st January 2019 was asked whether he thought the decision not to restrict Dr Watt on 23rd July 2017 was correct. He indicated he felt that because Dr Watt was at a conference the following week, there was time to clarify any issues and deal with ongoing concerns without jeopardising patient safety. Mr Young agreed and in his evidence to the Inquiry Panel of the 22nd April 2021 he stated:

I didn't have a clear expectation that I was going to hand over a letter and suspend Michael Watt.

We should have been much clearer. But it wasn't made clear to us, from what you have just said there in that synopsis, that no matter what Michael Watt was going to put forward, we were actually going to suspend him. At that time Michael Watt was not clinical. He wasn't practicing, and he was going to, I think an ABN meeting...and a period of leave, so we knew he wasn't going to be at work. He did give us a number of mitigations which we took the opportunity to go back and clarify. He didn't see any more patients during that period, so there was no impact. I suppose that is what gives us the buffer. Had he been clinical and had he been working the next day, I think then there would have been a different way of us looking at that, because then he would have been doing that. I absolutely know that Cathy Jack was really disappointed that it had not happened, but we did take that information back to her immediately after that

We were not given a brief to say, 'we expect you to hand over this letter, and we expect you to suspend Michael Watt with immediate effect.' We were told that if he didn't give us mitigations that we felt were robust enough, then we were to suspend him. We were unsure, and so we went back for clarification.

- 15.177 The Inquiry Panel have no doubt that Dr Jack believed that the letter signed by her restricting Dr Watt's practice was to be handed over. Unfortunately, the wording of the letter itself does give room for an explanation to be provided and Dr Mitchelson and Mr Young felt that they had time to seek such an explanation. In Dr Mitchelson's case, he was new to the post and his caution was more understandable. Mr Young should have sought clarity given his experience of similar situations, if he had any doubt about what was to take place. Further, if there was no doubt as to what must happen that should have been made clear to Dr Mitchelson and Mr Young prior to the meeting, given the language of the letter.

25th June 2017:

- 15.178 On 25th June 2017, Dr Craig forwarded Dr McDonnell's analysis of the Sativex case to Dr Jack, who then indicated her intention to interview Dr Watt herself later that week.

26th June 2017:

- 15.179 On 26th June, Nurse Chris McKee sent an email entitled 'SEA [INI 399] 8th June 2017' to an agreed distribution list: Dr McDonnell, Dr John McKinley, Consultant Neurologist, Mr Young, Mr Atkinson and Ms Lundy.
- 15.180 On the same day, Dr McKinley responded stating:

Patients are admitted under the care of a Consultant. The patient had a spinal procedure performed and was committed to complete bed rest by a consultant – is there not an obligation for the consultant to review VTE risk and prophylaxis in that setting?

- 15.181 The Inquiry has not had sight of any response to Dr McKinley's email.

27th June 2017:

- 15.182 Dr Jack, having received the minute of the meeting from Dr Mitchelson, met with Dr Watt on Tuesday 27th June alongside Mrs Owens and Mr Watson. It was agreed that Dr Watt would now proceed to go on sick leave until 14th July 2017, in the first instance.

15.183 On the same day, a further meeting was also convened between Mr Young, Dr Craig, Mr Atkinson and the Assistant Services Manager to discuss Dr Watt's upcoming clinics and make telephone contact with patients and potentially their GPs. Patient concerns were to be brought to the attention of Dr McDonnell. This meeting gives an overview of Dr Watt's commitments at that time and was recorded in the minutes as follows:

- 28 June 2017 – 37 patients on general/MS clinic list.
- 29 June 2017 – 45 patients on TIA clinic list.
- 3 July 2017 – 26 patients on TIA clinic list.
- 4 July 2017 – 35 patients on general/MS clinic list.
- Clinics on 5 and 6 July have previously been cancelled.
- There are 1928 active review patients on MW's waiting list.

MW's current inpatient/day case waiting list has 121 patients:

- 100 blood patches.
- 13 day cases
- 8 inpatients including Video EEG and assessments.

15.184 On 27th June, Ms Andrea Gormley, the Appraisal and Revalidation Co-ordinator also confirmed to Mr Watson that the most recent appraisal for Dr Watt related to practice year ending December 2013.

28th June 2017:

15.185 A series of interim steps were also agreed with Dr Watt, including discussion with his defence organisation, referral to Occupational Health Services, clarification regarding the reasons for prescribing Sativex and various other steps, which were set out in a letter of 28th June to Dr Watt from Dr Jack.

29th June 2017:

15.186 Email correspondence between Mrs Dianne Shanks of Hillsborough Private Clinic and Mr Watson indicated that Dr Watt had shared the 9th June letter outlining the partial restriction with the Medical Directors of Hillsborough Private Clinic. ("HPC") It appears that the letter was shared with them by Dr Watt on 19th June 2017. Miss Diane Graham from the Ulster Independent Clinic ("UIC") also confirmed at this time

that Dr Watt had shared the 9th June restriction letter with UIC in a timely way. Both Mrs Shanks and Miss Graham complained that the letter was not accompanied by the reports from Dr Gray and Dr McConville. In response to an email from Mr Watson highlighting this omission, Dr Watt explained to Mr Watson that he had not read the letter and thought that he was only required to leave the restriction letter and had not understood that he should enclose the reports from Dr Gray and Dr McConville. Reports were forwarded by Mr Watson to UIC and HPC on the same day.

15.187 Following a meeting on 29th June, Mr Watson forwarded an action note from Dr Jack to Mrs Owens and Mr Young containing 9 action points stating inter alia:

FY (Frank Young) to get GMcD (Gavin McDonnell) to review 80 charts of patients on second line DMT [Disease Modifying Treatment] for diagnosis treatment and documentation. FY may then need to get GMcD to review a general neurology clinic.

30th June 2017:

15.188 Ms McDonald, from the Complaints Department, emailed Ms Vincent and Ms Lundy to indicate that the response to the INI 399 complaint was still outstanding.

4th July 2017:

15.189 Mr McMullan, from Risk and Governance, wrote to the Health and Social Care Board stating as follows:

The Directorate has confirmed that they are continuing to review a number of patients with a diagnosis of MS and Blood Patch procedures. The Consultant in question is currently not in work.

14th July 2017:

15.190 On 14th July, following up on the numbered points in the letter of 28th June to Dr Watt, Mr Watson set out in a detailed memo to Dr Mitchelson, an update on the various actions to be taken. The salient points of some issues outlined in the memo were noted as follows:

- Dr Watt's NHS commitments being managed and arrangements should be maintained until 21st July, in the first instance.
- Dr Watt was to attend appointment with Occupational Health on 18th July.

- Contact had been made with Dr Mastihi of the Medical Protection Society (“MPS”).
- Work on validation and GP correspondence was at an advanced stage.
- Mr Watson had confirmed with Dr Watt that he remained on sick leave and would not practice clinically, including in the private sector.

15.191 On 14th July, the then Assistant Service Manager emailed Dr Mitchelson, Dr Jack, Mr Watson, Mr Young and Dr Craig with a blood patch procedure update, based on the spreadsheet compiled by Dr Peukert, which had given a breakdown in relation to patients awaiting a blood patch procedure as follows:

- 84 patients referred for BP, reviewed by Dr Peukert, not approved but remain on Active waiting list.
- 14 patients referred for BP, reviewed by Dr Peukert, approved and remain on active waiting list.
- 12 patients on active blood patch waiting list who will require a review of case by Dr Peukert. These cases will need to be confirmed with Dr Peukert upon his return next week.
- 9 patients not on active waiting list, but were referred for BP – it is unclear if this has been communicated with patients; again, these cases will need to be confirmed with Dr Peukert upon his return next week.

15.192 On the same day, Ms McDonald sent a further email to Ms Vincent and Ms Lundy in respect of the INI 399 complaint: *“This one needs an update.”*

18th July 2017:

15.193 On 18th July, Dr Mitchelson met with Dr Craig, Dr McDonnell and the Assistant Service Manager to respond in detail to the points raised by Mr Watson. At that point, it was hoped that there would be a limited case review carried out by the RCP, to be completed by the end of August. It was noted that Dr Watt had about 2,500 patients under review. Further work was to be done to the letter to patients and GPs and the wording had not been fully agreed. In relation to communication with staff, Dr Mitchelson stated, in an email to Mr Watson, as follows:

As with all these processes there are whispers and questions. Part of the challenge is that we don’t know what we are asking staff to do and for how long. We are also hoping that Michael makes a swift return and reintegrates smoothly back into the service. Additionally the service was under significant pressure in advance of this and has some of the highest waiting lists.

I would like to have a form of words that we can take to staff so that we can ask for their help in terms of service continuity and plan rotas and clinics accordingly. Maybe this should be discussed with Michael and it might be as simple as, “he is off on long-term sick leave and we are unsure of a return date”.

Whilst I do not think that there is much hope I believe that we should go out to advert for a locum but the above would need to be agreed first. I think there is limited risk with this as we have 2 unfilled posts, even on his return Michael’s workload will need to be controlled, and with him being off for an unspecified period, and with the reviews ongoing we will need extra capacity.

Further, just by being seen to undertake this process it will signal to the staff our willingness to try and help ease the current pressures.

20th July 2017:

15.194 On Thursday 20th July 2017, Dr Watt met with Dr Mitchelson and Mr Watson. Dr Watt, on this occasion, was accompanied by Dr Mastihi from the Medical Protection Society. Dr Watt submitted at the meeting that the proposed restriction on the totality of his clinical practice was unreasonable and unnecessary. He contended that the areas of concern related to only two areas of practice and that the restrictions previously indicated were adequate.

21st July 2017:

15.195 Although Dr Jack could not attend the meeting on 20th July, she wrote to Dr Watt the following day, on 21st July, and summarised the current position of concern as follows:

1. Index Cases – in relation to the 6 index cases, it is clear that the views of a number of Neurologists both within the Trust and outside of the Trust are that:
 - (a) Your practice in 3 cases was not within acceptable limits.
 - (b) Your practice in 2 cases was within acceptable limits.
 - (c) The position of the reviewers in relation to 1 case is currently under review.
2. A Case – it is accepted by you that your recorded basis for Sativex prescribing in this was incorrect. You will note from the report, by Consultant Neurologist Dr McDonnell, that there are concerns in relation to the diagnosis, prescribing practice (based on the records) and the adequacy of documentation.

3. B Case – I am advised that the internal review has indicated no concern in relation to diagnosis and treatment in this case, although concern did arise from a reference to the word, “suicide”. There was no further detail in relation to what this reference referred to, whether it was your assessment, or of any action which you took subsequently. It was therefore necessary for one of your colleagues to follow up on this reference with the patient’s GP.
4. C Case – I am advised that there are currently no outstanding concerns in relation to your practice regarding this patient, initially seen in the private sector, then in the NHS, and boarded to the DMTS waiting list. System issues within Neurology in relation to the boarding of patients are being considered.
5. Blood Patching – I am advised that of the 98 patients on the waiting list for blood patching, Dr Peukert, your colleague Consultant Neurologist who reviewed these, has advised that in his opinion, this is not appropriate for 84 patients, and appropriate for 14 patients.
6. 2nd Line DMT patients – I am advised that to date, Dr McDonnell has reviewed the charts for 3 of these patients, and no concern has been indicated regarding your practice in these cases.

15.196 While Dr Jack accepted that concern had arisen in only two areas of practice, she told the Inquiry Panel, as she had set out in her letter to Dr Watt of 21st July 2017, that the assessment regarding documentation, diagnostics and decision-making were transferrable to all areas of clinical practice.

15.197 In relation to the indication by Dr Watt at his meeting on 9th June with Mrs Owens and Dr Mitchelson that his practice was pressurised and possibly out of control, and that Dr Watt felt isolated and that he had pushed the boundaries of good practice, Dr Jack noted that the assessment from Occupational Health was that he was fit to practise. She felt, however, that this did not address the concerns, which Dr Watt had articulated himself, that he was overburdened. Whilst she felt that these matters could be addressed in time, Dr Jack wished to be assured that appropriate changes had been made to allow these issues to be managed effectively “*with patient safety potentially no longer compromised by these factors*”. In relation to the complete restriction of all clinical practice, Dr Jack stated:

I cannot accept the perpetuation of this situation given the potential risks to both patients and yourself. While there may not be concern arising in the context of “general” Neurology patients at present, I am concerned at the generic nature of some of the concerns identified by the reviewers to date, and which if

independently validated may give rise to concern in your wider practice.

While there had been previous discussion in relation to the current position with both NCAS and the Trust HR Director, given the views expressed at the meeting yesterday we have again consulted with these parties. NCAS and the Trust HR Director have agreed that restriction from all clinical duties is necessary and proportionate to ensure patient safety at this time. I can confirm that I am making this restriction within the framework of Maintaining High Professional Standards in the Modern HPSS.

I understand that Dr Mastihi indicated that in her view a restriction from all clinical duties amounted to an exclusion; I do not consider this to be the case and would hope that Dr Craig and yourself will be able to agree suitable non-clinical tasks. In any event, I consider that the clinical restriction is appropriate and proportionate to protect the interests of patients and yourself.

I would ask you to make contact with Dr Craig to discuss arrangements for your return to the workplace. It has been suggested that while restricted it may be helpful if you dedicate some time to appraisal, and other development opportunities.

- 15.198 Dr Jack concluded her correspondence by suggesting that Dr Watt's focus should be on completing the outstanding appraisal work and confirmed that she did not feel that supervised practice was a feasible option at that time. All matters were to be kept under review.

22nd July 2017:

- 15.199 The letter from Dr Jack was provided to Dr Watt on 22nd July 2017.

24th July 2017

- 15.200 On 24th July Mr Watson emailed Joanne Donnelly the GMC Employer Liaison Adviser and enclosed the letter from Dr Jack to Dr Watt dated 21st July 2017 which gave further details of the reasons behind the restriction.

25th July 2017:

- 15.201 On 25th July Mr Watson sent to Mr Young a recent complaint and further stated:

It would also be prudent at this time to seek from Complaints and Risk and, Governance details of any complaint incidents and litigation pertaining to Michael Watt in recent years.

15.202 The suggestion by Mr Watson was a critical step that should in the view of the Inquiry Panel been taken much earlier. Unfortunately, little seems to have been done to implement the suggestion and by the time the Patient Recall was announced in May 2018 the Medical Director was briefed in relation to earlier complaints, but in the view of the Inquiry Panel, these had been inadequately evaluated.

26th July 2017:

15.203 On 26th July, Mr Young emailed Mr Watson regarding an earlier request on 24th July from the Assistant Service Manager seeking an update in respect of the Early Alert. Mr Young stated:

Peter, Latest Early Alert communication to the DHSSPS. [Department of Health] Purposely keeping this to the bear [sic] minimum but now you may wish to provide a more detailed Alert update based on Cathy's letter. Frank

15.204 The earlier communication in response to request from Department of 30th June had been drafted by Nicky Vincent as follows:

In respect of an update we can advise that the Trust is continuing to review a number of patients with a diagnosis of MS and blood patch procedures.

The consultant in question is currently not in work.

The Trust is also in discussion with the College of Physicians for their personal assistance in a wider clinical review.

15.205 During his attendance on 16th May 2019, the Inquiry Panel asked Mr Young about the above reference to *'keeping this to the bare minimum'*. He told the Inquiry Panel:

Ok. I'll be completely honest with you. We had a suspicion that when we sent Early Alerts to the Department that there was a leak or a mole, and that very quickly after that, because there'd been a number of previous Early Alerts, that the media is, then, on the next day saying, "What is this?" So, we were purposely – not trying to hide anything; I just want to be clear about that – but it was so that we were doing this and we were controlling how this was going to be managed in terms of communicating to the patients ...

15.206 When asked by the Inquiry Panel, Mr Young was unable to offer a specific example of an occasion involving a "leak" or a "mole". The Inquiry Panel also discussed the matter with Ms Nicky Vincent, who stated that she was not familiar with this and explained:

Not on my side of the house, but I had heard of the odd case where there were concerns raised organisationally that, potentially, that might happen ...

from my perspective, I have always felt that it's best to keep absolutely on the right side of the Department and keep them abreast of what is happening and not to withhold anything so, certainly, the bare minimum, as I say, that is not something I would've been keen on.

27th July 2017:

- 15.207 The Early Alert update of 27th July 2017, references, inter alia, organisation of an urgent meeting between the Trust and Public Health Agency representatives *“in order to agree the appropriate next steps, inclusive of case note review.”*

EVIDENCE OF DR WATT

- 15.208 The fact that Dr Watt was medically unfit to appear before the Inquiry Panel, was unfortunate. It did not, however, prevent the Inquiry from fulfilling its Terms of Reference. In the absence of direct oral evidence from Dr Watt, the Inquiry did receive from the Belfast Trust a copy of the draft Verita report, which was part of the Maintaining High Professional Standards (“MHPS”) process managed in the case of Dr Watt by Dr Seamus O’Reilly, Medical Director in the Northern Health & Social Care Trust. Verita, an independent consultancy specialising in managing investigations for regulated organisations, acted as case investigators. Dr Chris Clough, Consultant Neurologist at King’s College Hospital, provided expert advice to the investigation team. Interviews with Dr Watt and his representative took place on 12th September 2018 and 28th May 2019. Ultimately the MHPS process was not completed as Dr Watt was unwell and not in a position to respond to the draft report.
- 15.209 Given that the interviews with Dr Watt in September 2018 and May 2019 are the only recorded response (apart from contemporaneous documentation) of Dr Watt to the issues that arose in his practice, they take on an additional significance. Out of fairness to Dr Watt, the Inquiry Panel believe that it is important to reflect Dr Watt’s response in some of the relevant chapters. Much of the evidence given to the Verita investigation is consistent with the concerns that he raised on 9th June 2017 when interviewed by Dr Mitchelson and Mrs Owens (see paragraph 150 above).
- 15.210 Set out below are relevant extracts of the evidence given by Dr Watt to the Verita investigation panel:

5.58 We have already noted Dr Watt’s concerns about his high workload. He told us that his this should be seen in the context of very long waiting lists and

an underresourced service. He said that he had *“a feeling that society had paid for you to be trained, and that you owed it to society to give something back”*. Dr Watt said that his attitude was that if someone needed to be seen, he would fit them in.

5.59 Dr Watt told us that he did not think that the numbers of patients that he saw were matched by other consultants. He told us *“some of the more recently-appointed people would have seen patients at a much more leisurely pace, some of their clinics were set up for the super-specialty template, so an hour for new, half an hour for review”*.

5.60 We asked Dr Watt how he responded to this environment. He told us:

“If you look at it now, I clearly cut corners on record-keeping and documenting examination, whether I examined them or not. I didn’t always examine patients, there’s no point in saying otherwise. I learnt a lot from just observing them, I watched them walk down the corridor, I sometimes went out and watched them walk out again if I suspected that they were putting it on a bit, I might have watched them leave, without them being aware of it.

“I would have watched them throughout the interview, how they moved and how they talked, and I suppose like a lot of us really, have a very good memory, so would have noticed changes in them, just from remembering what they were like the last time.”

5.62 We asked Dr Watt if he raised his concerns with management. He told us:

“We did, I asked my secretary at one point to ask the managers whether we could stop seeing new patients in one of clinics, or several of the clinics, because of the numbers, and that was denied. I suppose I also talked to John Craig about the possibility of working towards appointing somebody to share the clinics with, which would have the advantage of continuity of care when I retired, and also it would allow the clinics to run when I was off on leave – shared working to me seemed to be a good idea.”

- 15.211 Issues around the volume of Dr Watt’s practice have also been considered in the MDT/Peer Review chapter. It is highlighted in this chapter because June 2017 appears to be the first time that serious concerns were raised by Dr Watt. The Inquiry Panel has concluded that little thought was given to Dr Watt’s working patterns and the number of patients he was seeing because, in general, he was contributing as much, if not more than anyone, to reducing the chronic problem of neurology waiting lists.
- 15.212 Dr Watt was not the only consultant neurologist who went beyond the template drawn up for clinics in terms of the number of patients being seen. Further, he had, by any standards, an extraordinary work ethic, which resulted in him investing vast amounts of his time to his medical practice. Dr Watt raised no concern about the matter, save that, on one occasion, he acknowledged that he fell behind with

his paperwork. Nevertheless, if one had been able to view the entire picture of his practice, including his failure to get appraised, the number of complaints and other concerns that were being raised at various times prior to November 2016, the issue of overwork could again have been viewed as something to be investigated.

DISCUSSION FOR THE PERIOD NOVEMBER 2016 - JULY 2017

15.213 In considering the Terms of Reference, the Inquiry Panel took the view that this period should be considered in terms of the individuals who were involved, the processes, which either assisted or impeded the enquiries made and the overall context in which the restrictions and/or partial restrictions were put in place.

15.214 A detailed analysis of all the relevant matters is set out in the separate chapters of this report, but, for ease of reference, the critical areas of concern, which were known about in some part of the Trust system, prior to November 2016 in relation to Dr Watt's practice, are set out below:

- (i) The numerous clinical complaints made against Dr Watt, between the period 2007-2016, which were inadequately investigated and acted upon, or evaluated. This includes the case of INI 45, which was inadequately investigated by the GMC, as found in the review carried out by the GMC themselves in 2019. Insufficient investigation occurred at every level from the Service Directorate to the Regulator.
- (ii) Dr Watt's administrative failings were recognised and apparent from an early stage. The perception, however, developed that his difficulties with paperwork were not relevant to his clinical competence. A persistent failure to complete appraisal was regarded as an administrative failing. It had no bearing on the Trust's view of his clinical competence. The Inquiry Panel has concluded that the perceived narrative surrounding Dr Watt's clinical competence prevented and impeded an adequate investigation over many years, when significant opportunities were missed to identify a pattern of aberrant practice. These are amplified in the chapters relating to missed opportunities 2006/2007; 2012/2013 and 2016.
- (iii) Prescribing patterns in relation to the prescription of Human Immunoglobulin ("HIG") and Second Line Disease Modifying Treatments (DMTs), such as Alemtuzumab, were identified by individuals within the Public Health Agency and raised with both the Clinical Director and various approval panels. Despite this, there was no adequate investigation of Dr Watt's prescribing pattern. These issues are further explored in the Prescribing chapter.

- 15.215 A great deal of information was, therefore available to the Trust in November 2016. The Inquiry Panel accepts that it has the distinct advantage of having a lot more information than any of the decision-makers at the time of the relevant events, but the key point is that a lot of information was available, if it had been specifically sought. In 2016, concerns had been raised by 3 consultants in the Northern Trust, resulting in an independent report being obtained in relation to Dr Watt's treatment and diagnosis in contrast to the views of the 3 consultants in the Northern Trust, who had treated the same patient. The concerns raised by the Northern Trust consultants arguably assisted in identifying a previous pattern, even if potentially the most helpful question had not been asked of the independent neurologist Professor Wills. This was referred to in the note by Mr Watson in December 2016 but does not seem at any time to have been further reviewed. Additionally, a matter of weeks before Dr Fitzpatrick's phone call to Mr Watson on 17th November 2016, several complaints and other significant issues relating to Dr Watt had been considered by the Clinical Director and the Co-Director. These were not considered when it came to the assessment of Dr Fitzpatrick's concerns. Had all the systems worked effectively to ensure that the relevant information was available to the Trust, then this may have led to a consideration of a full clinical restriction in December 2016 and not July 2017.
- 15.216 The immediate escalation to the Clinical Director of Dr Fitzpatrick's concerns by the Senior Manager, Mr Watson, was entirely appropriate. It was further clear from the evidence in this instance that, in relation to the Dr Fitzpatrick complaint, the Clinical Director, Dr Craig, acted promptly and appropriately. It is the case that Dr Fitzpatrick, to reassure himself that his concerns in respect of multiple sclerosis were well-founded, liaised with Dr Gray, who subsequently became one of the independent reviewers. An argument was advanced by the Medical Director, Dr Jack, that Dr Fitzpatrick should have immediately informed her as to Dr Gray's stated views, which, though not in writing, clearly raised a concern about one of the MS cases, in particular. The Inquiry Panel notes that precisely the same written information was given to the Clinical Director, who advised that, while an independent review should be carried out by Dr Gray and Dr McConville, there was no immediate risk to patient safety. The Inquiry Panel notes that Dr Gray, when informally approached by Dr Fitzpatrick, was concerned about one index case and was reassured by the fact that the matter had been raised with the Medical Director's Office.
- 15.217 While, in retrospect, it would have been helpful had Dr Jack been aware of Dr Gray's provisional view, the Inquiry Panel have concluded that no criticism whatsoever should attach to Dr Fitzpatrick. He appropriately brought the relevant clinical

information to the right location, namely the Medical Director's Office. It was reasonable for Dr Fitzpatrick to assume that the information disclosed would be acted upon by the Medical Director's Office, which is what, in fact, transpired.

- 15.218 The Inquiry Panel notes that a partial restriction in respect of the diagnosis and treatment of Spontaneous Intracranial Hypotension ("SIH") was imposed by Dr Jack in December 2016. That was a justified step and led, within a matter of weeks, to the discovery that only a proportionately small number of patients were being accurately diagnosed by Dr Watt.
- 15.219 Dr Peukert, who took on the burden of review in relation to cases of SIH deserves to be commended. He was a much younger consultant, who, in fact, had trained under Dr Watt. It is notable in some of the email correspondence, how deferential he was to the position of Dr Watt, who was, at that stage, one of the most senior neurologists working in the Trust. It is to Dr Peukert's great credit that, on his own initiative, he drew up a detailed Excel spreadsheet, which demonstrated effectively that many of the patients being referred for a blood patch procedure, should not have been diagnosed in such a way and were undergoing a potentially harmful procedure. Dr Peukert's evidence led directly to an independent review of 48 of Dr Watt's cases by the Royal College of Physicians and was critical to the discovery of the scale of the problem. The fact that he was much younger and felt uncomfortable in taking on such a task, did not deflect him from his duty. The Inquiry Panel have reflected that the Trust should have been alive to the necessity of collating the evidence of Dr Peukert rather than leaving him to his own devices. It is also the case that when the extent of the problem became apparent following the disclosure of the Excel spread sheet, that a more comprehensive restriction in relation to the diagnosis and treatment of SIH was justified.
- 15.220 An issue also arose as to whether there was sufficient information available in the index cases identified by Dr Fitzpatrick in December 2016, to effect at least some degree of restriction on Dr Watt's MS practice. It is accepted that the commissioning of the reports from Dr Gray and Dr McConville was decided upon and ultimately this led to a partial restriction at the beginning of June 2017. The delay in obtaining the relevant notes and records and instructing Dr Gray and Dr McConville was unacceptable. The decision to exclude Dr McDonnell from giving his input in December 2016 because it was felt that he had already taken a view in respect of one of the index cases was a mistake. It is understandable that there was some degree of concern that Dr Gray and Dr McConville would be able to independently evaluate the relevant cases. The Inquiry Panel, however, does not believe that anything would

have been lost if Dr McDonnell had been briefed by Dr Craig and asked to give a view in December 2016. He had already seen one of the patients and disagreed clearly with Dr Watt's diagnosis of MS. The Inquiry Panel believes that discussion with Dr McDonnell may have reassured Dr Craig in formally advising Dr Jack to the point where a partial restriction may or may not have been imposed in December 2016.

15.221 The Inquiry Panel questioned Dr Craig, Mr Watson and Dr Peukert in detail about the ambit of the original partial restriction in relation to the diagnosis of SIH. Two outstanding questions remained unclear:

- (i) To what extent Dr Watt was required to check with Dr Peukert that additional blood patch procedures could be carried out on a patient, should earlier patches by Dr Watt be deemed to be unsuccessful if they had originally been referred by a neurologist or neurosurgeon? The evidence from Dr Peukert suggested that once a referral was received from a consultant neurologist or neurosurgeon then Dr Peukert did not review the case at any stage.
- (ii) Was it possible for other colleagues, apart from those in neurology or neurosurgery to refer patients to Dr Watt for a blood patch procedure and for that procedure to be carried out without reference to Dr Peukert?

15.222 In the view of the Inquiry Panel, there was an ambiguity in the restrictions that were imposed on Dr Watt. The documentation records that within hours of the restriction being imposed, Dr Watt was seeking to interpret the ambit of that restriction and was especially anxious to ensure that his patients received the treatment that he thought was appropriate and proper to give to them. An early decision was taken to allow for other neurologists, who themselves had diagnosed the condition of SIH, and who had referred the patient to Dr Watt for a blood patch procedure, to be in a different category. The understandable view was taken that, as there was no issue regarding Dr Watt's ability to carry out a blood patch procedure, and that other consultants were not under question about their ability to diagnose SIH, it was appropriate for Dr Watt to carry out blood patch procedures in such instances.

15.223 In December 2016, Dr Hunt referred a patient to Dr Watt for an opinion. Dr Watt approached this case with a degree of certainty, which was taken in good faith by his colleagues. The Inquiry Panel is not in a position to adequately evaluate whether this was simply assumption on the part of Dr Watt, but the fact remains that a patient was referred for an opinion and Dr Watt concluded that a blood patch procedure was justified. Given Dr Watt's clinical enthusiasm for a diagnosis of SIH, even in the

absence of imaging evidence, his approach was not surprising. The Inquiry Panel believes that it is highly likely that many of the referrals made by other consultants were made on a similar basis to that of Dr Hunt. Thus, it may well be the case that a number of patients, who Dr Peukert believed fell outside the terms of the partial restriction, may have been inappropriately treated by way of a blood patch procedure. The Inquiry Panel does not consider any such outcome to have been due to the actions of Dr Peukert. Any inappropriate blood patches occurred as a result of differing interpretations of the partial restriction.

- 15.224 The Inquiry Panel also discovered other ambiguities. It was apparent from the evidence that patients who received one blood patch procedure often went on to undergo numerous other blood patch procedures either when it was perceived that the first procedure had not worked or the efficacy of the patch procedure had, in the perception of the patient, diminished. As the Inquiry Panel, and Dr Jack, interpreted the restriction, Dr Watt would have required Dr Peukert's approval for a second or further blood patch procedure(s) in circumstances where he had secured Dr Peukert's approval for the initial diagnosis by Dr Watt of SIH. However, this was not communicated to Dr Peukert and he advised the Inquiry Panel that if he had approved treatment, after diagnosis of SIH he did not consider that Dr Watt required further approval for subsequent treatment by way of blood patch procedures. Similarly, where other consultants referred a patient to Dr Watt for a blood patch, and Dr Watt subsequently considered it appropriate to carry out further procedures, approval would not have been sought from Dr Peukert for any additional treatment.
- 15.225 The Inquiry Panel recognises that a partial restriction is much more difficult to manage because it often involves questions of interpretation. In Dr Watt's case, difficulties were compounded by the limited number of people who were aware of the restriction. Dr Peukert, on his own initiative, compiled an Excel spreadsheet of all requests by Dr Watt for patients to receive a blood patch. This was of inestimable assistance in understanding the ambit of the problem because it highlighted in table form, the precise numbers who had been referred. The Blood Patch chapter sets out in precise detail the relevant figures, but, in summary, by March 2017, Dr Peukert had approved only 12 of 87 patients who had been referred by Dr Watt.
- 15.226 Without Dr Peukert's careful analysis of each case, the Inquiry Panel has concluded that there would have been, at the very least, a delay in understanding the significance of the problem that had been discovered.

- 15.227 While due allowance needs to be made for ambiguity which can arise, the fact is that the partial restriction was interpreted in a varied manner by different people. The Inquiry Panel would highlight the fact that Dr Peukert believed that once approval was given for one procedure, then his approval would also relate to subsequent procedures on the same patient. This was not Dr Jack's understanding and as some patients underwent multiple procedures, the difference in interpretation had significant effect. The ambiguity highlighted the difficulty with partial restriction and it would have been better if a complete restriction in respect of the diagnosis and treatment of SIH had been imposed when Dr Peukert's figures became available and had been considered by the Medical Director.
- 15.228 A similar ambiguity existed in relation to a diagnosis being made by not just neurologists, but also neurosurgeons and neuro-radiologists. The Inquiry Panel believe that we will never fully know the precise number of patients who were referred to Dr Watt for a blood patch procedure. It is, nevertheless, clear from the evidence that the number of procedures was out of all proportion to what had previously occurred within the Belfast Trust. Dr Watt had, on three separate occasions, including in March 2017, given a presentation in the Neurosciences Grand Round Meeting, of patients whom he had treated for SIH. The evidence suggests that Dr Watt had come to the view that SIH was substantially under-diagnosed and that, even in those cases where there was a lack of objective evidence from the imaging carried out, this did not prevent, in many cases, a diagnosis being made. While the Inquiry Panel understands that there can be cases where a lack of imaging does not preclude a diagnosis, the evidence suggests that one would normally expect an imaging abnormality to be present. This is dealt with in greater detail in the chapter on Blood Patching.
- 15.229 Dr Watt's zeal for the procedure is illustrated well by the incident, which took place in the Ulster Independent Clinic in March 2017. Dr Hunt gave clear evidence that he was approached by Dr Watt to confirm the diagnoses in relation to probably five patients, who Dr Watt had concluded needed a blood patch procedure as they were suffering from SIH. Dr Hunt very properly and wisely carried out his own assessment. He disagreed with Dr Watt in respect of each case. He was aware from Dr Watt, who was quite open about the matter, that some sort of restriction had been imposed. He was so concerned about the differences in diagnoses, that he raised the matter with Mr Young, the Co-Director in the Neurology Services Division.
- 15.230 Mr Young immediately responded by email to Dr Hunt on the same day that Dr Hunt had met with him (27th March 2017). Mr Young told the Inquiry Panel on 16th May 2019, that it was Dr Hunt who wished to keep the matter on an informal basis.

This was disputed by Dr Hunt in evidence on 9th September 2019, although he accepted that he had not challenged Mr Young at the time. In the view of the Inquiry Panel, the issue of informality is irrelevant. Mr Young should have been aware that such a disclosure would need to have been escalated to the Medical Director, particularly because Dr Watt was under a partial restriction. It is now apparent from the investigations that were carried out by the Inquiry, that Mr Young did discuss the matter with both Dr Craig and Dr Mitchelson. To what extent he properly reflected the conversation with Dr Hunt is unclear. The fact remains, however, that neither Mr Young, Dr Mitchelson nor Dr Craig sought to raise the matter with the Medical Director. In the view of the Inquiry Panel, the main responsibility to do so lay with Mr Young as he had received the information from Dr Hunt directly.

- 15.231 The gravity of the potential breach does not seem to have been appreciated at the time by Mr Young. While Dr Craig and Dr Mitchelson were clearly aware in some manner, they have little recollection of either conversations or meetings with Mr Young. The fact remains, however, that not just Mr Young, but also Dr Craig and Dr Mitchelson should have appreciated that Dr Watt was not adhering to, at the very least, the spirit of the restriction. This was also a problem because the partial restriction was not clear, especially with regard to repeat blood patch procedures. Mr Young believes that he, at some stage, informed Mrs Owens and Dr Jack about his conversation with Dr Hunt. The Inquiry Panel believes that Mr Young's recollection is mistaken and accepts Dr Jack's evidence that she was not aware of this incident until papers were received from the Inquiry. The Inquiry Panel further believes that, had Dr Jack been aware of this development, a further or revised clinical restriction would probably have been implemented in March 2017.
- 15.232 The issue of whether earlier restrictions should have been imposed in respect of Dr Watt's practice regarding multiple sclerosis patients was an important focus of the evidence received in relation to the period November 2016 to July 2017. The facts of what actually happened are as follows:
- (i) On 17th November 2016, Dr Fitzpatrick called Mr Watson in relation to three cases arising out of his practice in Comber, Co Down. Two of those cases involved concerns about the diagnoses of multiple sclerosis.
 - (ii) On 20th November, Dr Fitzpatrick contacted Dr Gray, a friend, and asked her to consider two case history summaries in relation to the two multiple sclerosis patients. Dr Gray was a neurologist in the Ulster Hospital and had a speciality in multiple sclerosis. Dr Gray had an immediate concern in relation to one of the patients. She satisfied herself that Dr Fitzpatrick had brought the matter to the attention of the Belfast Trust.

- (iii) On 22nd November, Dr Fitzpatrick spoke to Dr Craig and the same details as those forwarded to Dr Gray, were forwarded to Dr Craig.
- (iv) At the meeting on 1st December 2016, Dr Craig had written a question mark and delta sign, in relation to the MS cases. This would have been an ideal time to have consulted with Dr McDonnell who, in fact, had already taken a different view to Dr Watt in relation to one of the index cases as part of an examination that he carried out of the patient as part of his NHS duties. Dr Craig believed that Dr McDonnell, because of his involvement, could not be part of the independent review, which was ultimately carried out by Dr Gray and Dr McConville. Dr Craig's assessment at that stage in respect of the MS cases was that there was no immediate patient safety concern and the Inquiry Panel accepts that he gave that reassurance to Dr Jack indirectly through Mr Watson. The Inquiry Panel believes that Dr Craig, if he had consulted with Dr McDonnell, would have been in a much stronger position to advise Dr Jack.
- (v) Initially, the review was to be carried out by Dr Craig and Dr Gray, but when it became clear that Dr Craig had himself raised an index case in respect of SIH, it was felt by Dr Jack that Dr Craig could not be a part of the review. Dr Gray did not inform Dr Craig that she had been approached by Dr Fitzpatrick. It is difficult to determine whether Dr Gray was aware at any stage that the cases referred by Dr Craig for a report to be carried out included 2 of the index cases already given to her in November 2016 for review by Dr Fitzpatrick. Dr Gray agreed to carry out the review.
- (vi) Dr McConville was also approached and expressed a willingness to also conduct the review separately from Dr Gray.
- (vii) The relevant patient notes were not obtained until 24th March 2017. The report from Dr Gray and Dr McConville was provided by 1st June 2017.
- (viii) Dr Gray and Dr McConville expressed concerns in respect of both MS cases. While there was some clarity sought by Dr Jack as to whether one of the cases was outside the range of reasonable practice, the concerns raised by Dr Gray and Dr McConville were shared by Dr Craig and Dr McDonnell (an MS specialist) and were also confirmed by the subsequent RCP report.
- (ix) As a result of the Gray/McConville reports, further clinical restrictions were placed on Dr Watt in that he was to liaise with Dr McDonnell in respect of any new diagnosis of MS or treatment changes from First Line to Second Line for those already diagnosed with MS.
- (x) The restrictions were imposed on Dr Watt on 9th June 2017. Full clinical restrictions effectively commenced on 27th June and were confirmed by Dr Jack on 20th July 2017.

15.233 While action was clearly taken by means of an independent review to be carried out by Dr McConville and Dr Gray, the Inquiry Panel identified a range of concerns and failures, which can be summarised as follows:

- (i) It was agreed by all parties that the length of time taken (over three and a half months) to obtain the notes was a serious matter, which was not properly addressed at the time.
- (ii) Some of the confusion, which surrounded the obtaining of the notes arose because there was insufficient clarity about responsibility for the overall process and responsibility for carrying out various tasks contained within that overall process.
- (iii) The fact that information was retained in different systems prevented any look-back and reflection upon other incidents in Dr Watt's career as a consultant. It also precluded the ability to identify any pattern that emerged. This was, in the view of the Inquiry Panel, a failing. The Inquiry Panel notes the opportunities that were missed in 2006-2007, 2011-2012 and in early 2016 and has devoted specific chapters to the incidents that occurred during those years. The fact that information was retained in administrative silos, made it difficult for the Medical Director to be able to review patterns of concern, which should have been obvious and apparent.
- (iv) There was no clear delegation as to who should draw up the Terms of Reference for the partial restriction and questions to be posed to Dr Gray and Dr McConville, when Dr Craig was less involved in the process because he had himself raised a case of concern involving SIH.
- (v) It was unfortunate that Dr Gray had not indicated to Dr Craig that she had already spoken to a GP regarding a neurology consultant just a few weeks earlier and did not seem to appreciate that the consultant in question was Dr Watt. This may well have been apparent from the case history summaries, given that the consultant involved was identified as carrying out private work and it is surprising that Dr Gray did not make the connection.
- (vi) The Inquiry Panel is of the view that, had Dr Jack been given the views of Dr Gray in December 2016, she would have acted to impose restrictions in respect of Dr Watt's practice regarding patients with multiple sclerosis. It is likely that, at that juncture, the restrictions imposed would have been similar to the restrictions that were subsequently agreed in June 2017.
- (vii) The concern raised with Dr Craig and Dr McDonnell on 27th April 2017 by Dr Peukert, regarding a patient who had been diagnosed by Dr Watt

as having multiple sclerosis, should have been immediately forwarded to the Medical Director, Dr Jack.

15.234 During the period November 2016 to July 2017, other relevant events occurred, which should have been brought to the attention of the Medical Director or raised a concern within the Service Directorate. The Inquiry Panel would highlight:

- (i) The fact that Dr Watt decided to give a further presentation on patients suffering from SIH in March 2017 when he was under a partial restriction. This does not seem to have been commented upon by those who were aware of the restriction.
- (ii) The absence of an Associate Medical Director, or their equivalent, meant that Dr Mitchelson, the new Chair of Division on the medical side, did not come into post until January 2017. Ordinarily, Dr Mitchelson would have carried significant responsibility for the investigation and oversight of the process. The briefing given to Dr Mitchelson was inadequate and contributed to a confusion regarding the roles of those who were responsible for the overall process.
- (iii) Dr McDonnell, the Clinical Lead in Neurology, was not informed of the original concerns by Dr Fitzpatrick in November 2016. This was on the basis that he had treated one of the patients, whose diagnosis was the subject of complaint by Dr Fitzpatrick. In Dr Craig's view, the fact that Dr McDonnell had already undiagnosed one of the MS patients, meant that he could not be involved in the independent review. As it transpired, however, Dr McDonnell was unaware of the concerns and the partial restriction. The Inquiry Panel believes that he could have had a useful input into the MS complaints at the earliest stage, even if he was only reassuring or assisting Dr Craig in his advice to the Medical Director on restricting Dr Watt's MS practice. Further, he was not informed of the partial restriction and, in the view of the Inquiry Panel, should have been, because he was the Clinical Lead, his views would have been of interest and weight.
- (iv) Communication with patients and the patients' GPs was delayed and had too much input from too many people. The overall result was that patients were not communicated with properly for many months and this increased the level of concern.

15.235 It is important to acknowledge, standing back from the detail of events post-November 2016 that the substantive actions taken by the Medical Director were commendable. The partial restriction imposed within a few weeks of the initial complaint was prompt and decisive. The decision of Dr Jack, in conjunction with

Dr Craig, to ask Dr Gray and Dr McConville to consider some of the index cases was again timeous and appropriate, although it is disappointing that the review took longer than should have been the case because of a delay in ensuring that Dr Gray and Dr McConville had the appropriate records and questions. The decision to seek an independent review from the Royal College of Physicians was also an appropriate step, which ultimately proved to be crucial to the ultimate decision to recall patients. Finally, the decision to effectively suspend Dr Watt from practice by Dr Jack was the correct decision in the circumstances.

- 15.236 The primary decisions taken between December 2016 and July 2017 demonstrated that a Medical Director was in post, who was prepared to act when the evidence justified steps being taken. The Inquiry Panel would highlight the decision to partially restrict Dr Watt in December 2016; the obtaining via Dr Craig of the Gray/McConville report; the restrictions imposed following receipt of the Gray/McConville report with regard to multiple sclerosis; the decision to obtain a case note review of 48 specific cases under the direction of the Royal College of Physicians and the ultimate decision to prevent Dr Watt from seeing patients in July 2017. This report inevitably goes into a lot more detail on the precise events during this period and makes a number of criticisms, which in the view of the Inquiry Panel, highlighted a broader governance problem. Nevertheless, those criticisms do need to be seen in the context of major decisions being taken by the Medical Director, which ultimately resulted in the patient recall exercise.
- 15.237 Having reviewed the present complaints system and the manner of its working, the Inquiry Panel is of the view that one of the critical factors in ensuring that the problems in neurology became apparent was the decision by Dr Fitzpatrick to contact the Medical Director's Office rather than the Complaints Department. The Inquiry Panel is of the view that, had the manner been approached as a patient complaint, then it is unlikely that an alarm would have sounded. The cases would have been referred to the Service Department within neurology. Dr Watt would have been asked for his views. The response may or may not have been 'sense checked' by Dr Craig, but there would have been no independent outside clinical input. The draft reply would then have been forwarded to Mr Young and Mrs Owens for final approval. It seems inherently unlikely, having regard to the handling of the numerous other relevant complaints, that any further action would have been taken or that the Medical Director would have been informed.

EVIDENCE: AUGUST 2017-APRIL 2018

1st August 2017:

15.238 On 1st August, Dr Brid Farrell, Assistant Director of Service Development Safety & Quality at the Public Health Agency (“PHA”), wrote to Dr Carolyn Harper at the Public Health Agency following a conversation with Dr Jack. The body of the email stated as follows:

I spoke to Cathy Jack about this today. Early alert details are up to date.

Individual is not working clinically since 27th June in either HSC or private practice.

Since December 2016 practice has been restricted in management of Spontaneous Intracranial hypotension and dural patching and a second check made of clinical decision making.

May 2017 concerns raised re second line therapy and MS> Practice was restricted in starting therapy for MS.

More recently concerns re documentation applicable to other clinical areas in neurology e.g. prescribing Sativex for smoking cessation, describing a patient as suicidal but no follow up arranged.

Following the December notification they reviewed 6 index cases initially where 3 concerns were identified and subsequently reviewed all cases needing dural patches where there were 84 concerns out of 98.

Case discussed with NCAS and ELA (GMC). Early alert issued to HSCB and DoH. He has been referred to occupational health.

Plan is to engage with the College of Neurologists to do independent review of 6 index cases, Sativex prescribing, suicidal case, 5 random blood patches, 5 no concerns, 5 first line DMD, 5 second line DMD, 20 from general neurological conditions to review documentation, investigations and diagnoses.

He is delayed on annual appraisal.

15.239 Dr Jack updated Dr Farrell again on 2nd August, when she forwarded correspondence between the Trust and Dr Watt and set out the ambit of the case note review by the Royal College of Physicians. In summary, 48 cases were to be sent to the RCP, comprising:

- (i) 6 index cases.

- (ii) 5 randomly selected blood patching cases deemed NOT appropriate by Dr Peukert.
- (iii) 5 randomly selected blood patching cases completed by Dr Watt.
- (iv) 10 additional randomly selected MS patient case notes, inclusive of those on first line DMT's (5) and those on second line DMT's (5).
- (v) Case notes from a general neurology clinic, exclusive of MS/intracranial hypotension cases; it was estimated that this would include circa 20 cases.
- (vi) The A case.
- (vii) The B case.

15.240 Dr Jack then sought confirmation from the PHA that such an approach was acceptable.

3rd August 2017:

15.241 On 3rd August, a meeting took place between Dr Cathy Jack and Ms Joanne Donnelly, the Employer Liaison Adviser ("ELA") to the General Medical Council. Dr Jack advised Ms Donnelly that she would take proactive steps to ensure the Independent Sector was informed of restrictions. She also indicated that Dr Watt's most recent appraisal was in 2013. Ms Donnelly noted that the Belfast Trust had not previously highlighted his failure to engage in appraisal at previous Responsible Officer meetings where the ELA routinely asked the Responsible Officer about non-engagement concerns. This should have occurred.

15.242 At the meeting on 3rd August 2017, Ms Donnelly indicated that asking Dr Watt to share correspondence with the private sector himself was undesirable. The Inquiry has had sight of the internal GMC correspondence which contains advice from the GMC Medical Case Examiner to the ELA in the following terms:

There is no information in relation to the doctor's willingness to comply with the conditions, although there is no information to the contrary. I am concerned, as you are that in Dr [Watt's] private practice, divergence from conventional approaches may be less constrained, and we need more reassurance than a bland acknowledgement that the relevant medical directors have been informed.'

15.243 At this meeting, it is noted that Dr Jack advised:

She intends to proactively seek confirmation from the Ulster Independent Clinic and Hillsborough clinic that they are aware of the concerns, that they have imposed the same restrictions, and that they will inform her if there have been any concerns about Dr Watt.

4th August 2017:

15.244 On 4th August, Dr Peukert emailed Dr Craig and Dr McDonnell about concerns regarding an MS patient of Dr Watt that he had first raised in April 2017. Dr McDonnell had arranged for further tests to be carried out and Dr Peukert noted that the updated MRI *“did not show any evidence of demyelination.”* Dr Peukert further stated: *“As I am not a MS specialist I feel this patient should be reviewed. I am aware that MS might present with a normal MRI scan.”*

7th August 2017:

15.245 On 7th August, Dr Farrell from the PHA emailed Dr Jack and confirmed that the PHA was content with the proposed review of practice outlined by the Belfast Trust.

8th August 2017:

15.246 Dr Jack wrote to Ms Donnelly on 8th August indicating her intention to ensure that the independent sector was made aware of restrictions by forwarding correspondence directly to them.

15.247 On the same day, Mr Watson wrote to Mr Peter Ramsey-Baggs, the Responsible Officer at the Ulster Independent Clinic, and Dr Jim Sharkey at Hillsborough Private Clinic confirming that Dr Watt was restricted from all clinical duties and outlining the relevant concerns.

11th August 2017:

15.248 On 11th August, Dr Jack wrote to the Royal College of Physicians, (copying in the Public Health Agency) enclosing a *pro forma* request for a Clinical Record Review, which set out the background to the case note review.

15th August 2017:

15.249 On 15th August, Ms Donnelly wrote to Dr Jack following the meeting on 3rd August, setting out, in considerable detail, her overview of the situation as explained by Dr Jack. Ms Donnelly summarised her thoughts as follows:

- The main concerns in relation to Mr Watt’s practice appear to be the diagnosis and treatment of intracranial Hypotension, and MS. The allegation/concern seems to be that Mr W’s perhaps over-aggressive

approach to both, could cause real harm to patients. Especially in the case of MS, patients may be unable to get mortgages, may make precipitate life choices, or lose employment, and other social consequences. High dose steroid medications can have significant side effects and morbidity. Blood patches have caused their own morbidity in the patients, requiring medication. It is initially potentially alarming that Dr Watt appears, subject to further investigation, to be prepared to administer potentially hazardous 'blood patching' treatment unnecessarily to 84 patients – the opinion of an appropriate expert will be essential in this regard.

- The concerns in relation to record keeping and lack of examination are, of course, of concern in relation to Mr Watt's entire range of clinical responsibility. It would be important to clarify that the concerns have only been seen to date in the subspecialty areas of practice, but MAY be transferrable to other areas of practice inclusive of general Neurology.
- There is a potential public interest in this case, if it is shown by the planned review that Mr W's practice is significantly divergent from others.
- I reflected that there is no information in relation to the doctor's willingness to comply with the conditions, although there is no information to the contrary. However, you advised at our meeting that Mr Watt is in fact willing to comply with the local conditions and that he appreciates the seriousness of the allegations.
- In Mr Watt's private practice, divergence from conventional approaches may be less constrained, and you will wish to have more reassurance than a bland acknowledgement that the relevant medical directors have been informed.

15.250 Ms Donnelly went on to advise that, if the RCP review yielded alarming results showing actual harm to patients, then a further look-back would be required and that the threshold for GMC referral was likely to be met. In response to Ms Donnelly's views on the matter, Dr Jack confirmed that she had information from the Ulster Independent Clinic and the Hillsborough Private Clinic ("HPC") that they were aware of the concerns regarding Dr Watt, had imposed the same restrictions, and stated that there were no concerns in relation to Dr Watt in their organisations. Dr Jack indicated that the case review by the Royal College of Physicians was to be completed in early autumn 2017 and that a larger scale patient review would be initiated, assuming the approval of the Public Health Agency, if the concerns now raised were confirmed. The Inquiry Panel comments in the Independent Sector chapter on the statement by UIC and HPC and that there were "no concerns" in either the UIC or the Hillsborough Private Clinic was unintentionally misleading.

Although the Inquiry Panel accepts that medical staff did not have concerns in either clinic, several relevant complaints had been submitted to the UIC, and the Hillsborough Clinic had been in contact with the GMC in 2013 about patient INI 45. This should have been disclosed at the time.

- 15.251 In relation to Dr Watt's non-engagement in appraisal, Dr Jack commented that: *"systems are now in place to ensure that doctors will not be able to miss their appraisals without the non-engagement process being triggered"*. Ms Donnelly summarised her understanding of Dr Watt's position with regard to appraisal:

Dr Watt has not submitted any appraisals since Practice Year Ending December 2013 (meeting took place on 21 November 2014). He has received several reminders in relation to 2014, 2015 and 2016 appraisals (from MD, Deputy MD, AMD, Workforce Office, MDO Appraisal & Revalidation Office). Last reminder was on 13 July 2017. Further reminder being issued in September 2017 from Chair of Division. This would therefore indicate that Dr Watt is not engaging with a core process that supports medical revalidation, though he had advised his appraiser at one stage that he was working on a combined 2014 and 2015 appraisal to be completed by mid-October 2016 (advised on 29 September 2016). As his revalidation date is 26 September 2018, Dr Watt was contacted on 20 December 2016 to commence his Colleague and Patient Feedback surveys, and they were set up on the CPF system which issues regular reminders. These are core processes for revalidation which are facilitated by the Trust. Dr Watt has not yet progressed both surveys. A non-engagement process has not yet been initiated.

21st August 2017:

- 15.252 In response to a detailed email from Dr Jack on 8th August to the Ulster Independent Clinic, Dr Colin Russell, the Chairman of the Clinical Governance Committee acknowledged that Dr Watt was restricted from all clinical duties since 22nd July 2017 and further stated:

I am 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 past 3 years.

- 15.253 This statement was in fact incorrect, as discussed in the Independent Sector chapter. A significant complaint had been received within the past 3 years and Dr Jack should have been alerted as Dr Watt's Responsible Officer.

29th August 2017:

- 15.254 The Early Alert notification was updated in correspondence between Mr Colin McMullan and Ms Geraldine McArdle from the Health & Social Care Board. The response stated:

The Trust is continuing discussions with the Royal College of Physicians in relation to a case-note review. Dr Brid Farrell of the PHA has been updated. An update will be provided in due course with the review likely to be completed in the Autumn. At this stage it is not considered that an SAI is indicated.

7th September 2017:

- 15.255 On 7th September, a Trust Board Meeting took place. Dr Jack was present. Mrs Bernie Owens was noted in apologies. No mention of the issues regarding Dr Watt was recorded in the minutes of this meeting.
- 15.256 The Non-Executive Directors, who gave evidence to the Inquiry Panel on 10th September 2019, indicated that, at the meeting, Dr Jack had given an oral update. This was not included in the confidential Trust Board Meeting minutes either. However, a number of Non-Executive Directors had a clear recollection of the briefing:

Ms Karp: I think, in September '17, we had a verbal -- and a neurologist had been restricted in his practice. ... We were told the doctor had been restricted – and the doctor had been restricted from December 2016, actually – and those restrictions had been reviewed and strengthened until he'd been totally restricted on the 22nd of July. So, from a patient safety point of view, there was no further risk, had there been – risk to patient safety from July 2017 in terms of the actions.

Professor Jones: In September '17, there was an oral overview.... It was to do with harm to patients and early alerts at that time.

Professor Bradley: The 7th of September 2017. We had -- Cathy Jack gave us a verbal update in relation to there being an issue with neurology, and that was a verbal update.

9th September 2017:

- 15.257 On 9th September, Ms Quinn emailed Ms McClenaghan in regards to the INI 399 complaint: *"I met Clare Lundy a few times re this. She was already investigating this as an SEA. Report is written but there are a few issues to be resolved."* The Inquiry has had sight of internal email correspondence within the Belfast Trust, which suggests that a draft complaint response was in circulation by 12th September.

18th September 2017:

- 15.258 Dr Mark Mitchelson wrote directly to Dr Watt asking him to ensure that he undertook appraisal. Dr Watt responded on 19th September saying that he would be able to get on with appraisal in the next few weeks.

20th September 2017:

- 15.259 On 20th September, revised versions of the letters for patients waiting for epidural blood patch procedures in neurology were prepared and circulated for comment.

22nd September 2017:

- 15.260 Dr Mitchelson replied to Dr Watt's email, noting that Dr Watt was feeling somewhat better, offering the services of Occupational Health and seeking to emphasise the importance of completing Dr Watt's appraisals.

3rd October 2017:

- 15.261 Dr John Craig confirmed that Dr Gavin McDonnell had completed his review of those patients on second line therapies for multiple sclerosis.

4th October 2017:

- 15.262 By 4th October, an appraisal date for Dr Watt had still not been arranged, but, eventually, an appointment was confirmed for Monday 23rd October with Dr John Craig.

12th October 2017:

- 15.263 Dr Watt indicated that he had arranged to meet Dr Craig for his appraisal on 23rd October 2017.

19th October 2017:

- 15.264 Dr Jack met with Dr Craig, Dr Mitchelson, Dr McDonnell, Mr Young, Mr Atkinson and Mr Watson to review various matters. Following the meeting, Dr Jack emailed the attendees and copied in Mrs Owens. In her email, Dr Jack indicated that the RCP report would be completed by early 2018. She noted that Dr McDonnell had carried out a review of those patients on second line DMTs and further stated:

... We are also conscious that there are various cohorts of patients, including those on 1st line DMTs, those with ICH diagnosis, general neurology etc, and are agreed that Frank and Mark should lead on identifying cohorts of patients as far as possible, so that we can then firstly prioritise which cohorts should be considered first, and the action plan for each of those cohorts. I also would encourage you to consider how other disciplines (e.g. MS Nurses) may be able to support us in our response to the service pressures. It may also be informative to identify the Trust area of residence of these patients, if as we expect there will need to be a regional response to the pressures ...

15.265 In oral evidence on 18th June 2019, Mr Young confirmed that Dr Jack had asked him to carry out a review of those on second line DMTs in October:

There were a number – a series of meetings where we actually got together, where John and – principally would've identified all of the drugs, and then, in a kind of a risk matrix, to say "Number 1" down to whatever, and then we would've involved Clare Lundy and the medical records team to pull all of those charts so that they could be reviewed. And then ensure that patients were followed up appropriately.

15.266 This prioritisation given to second line DMT's was also reflected in the Royal College of Physicians' correspondence of 20th December 2017, wherein it stated: *"we feel that there should be a particular focus on patients on disease modifying therapies for multiple sclerosis, similar to that described of those patients on the waiting list for blood patching."*

15.267 Dr McDonnell gave evidence in relation to this process during his attendance before the Inquiry Panel on 1st February 2019:

In that time period, clearly, there were a lot of patients belonging to Dr Watt. I think he had about 3,200 patients under active review, certainly on the NHS, by the time he was going off in June 2017. I think in that pre-recall ... we saw over 600 of his patients, so that was a significant chunk of those patients. From an MS perspective, I think we had seen something like – we saw about a third of his MS population during that time period.

There was a particular concern that patients on some of the higher risk medications are left without a neurologist and are not being monitored effectively in terms of the safety of those drugs and in terms of the appropriateness of those medications. So, during that pre-recall period, we actually had a particular focus on those patients who were receiving drugs such as alemtuzumab and natalizumab, which are fairly high-end medications ... They are excellent drugs, they are expensive drugs, but there are significant safety issues associated with them. There was also a population of patients who were actually on a waiting list to start on one of those drugs. So, again, there was concern that people were

effectively, potentially, drifting, either on no treatment or an ineffective treatment, so there was an urgency about trying to get those patients seen as well.

So ... this really was about patient care, and it was about continuity of care. Now, again, there's an exercise in there, and I'm going to come back to it later on, where I was asked to actually go through – it was sort of a desktop exercise – notes and ECR records on patients on those high-end, higher-risk medications.

- 15.268 During this period, the Complaints Department in the Belfast Trust received a number of complaints from patients who wanted to obtain follow-up appointments in respect of a diagnosis of SIH. In general, patients wished to know why the blood patch procedures had been stopped and when they would be seen again.

31st October 2017:

- 15.269 Around 31st October 2017, Dr Farrell went on leave. When asked by the Inquiry, during her attendance on 4th November 2019, who would have handled the Early Alert in her absence she indicated:

Well, there would have been a system in place for – as you'll see in the papers, there would have been regular contact with the Trust in relation to the Early Alert and can it be moved over to a Serious Adverse Incident ... these are automatic letters that our governance people generate, every time there's an Early Alert, to see whether or not it should be an SAI.

1st November 2017:

- 15.270 Further amendments were made to the letter to patients on 1st November 2017 and patient letters were eventually posted out on 8th November with letters to GPs. It is clear that Mrs Owens, who had got involved in the situation, brought greater direction and focus to this issue. The correspondence with GPs explained as follows:

I am writing to you on behalf of the Neurology Service at the Belfast Health and Social Care Trust. The Trust is in the process of reviewing the records of patients attending the Neurology Service who are waiting for an epidural blood patch. This was instigated following a number of concerns regarding the requirements for epidural blood patching in patients thought to have possible intracranial hypotension. Whilst there have been no reported incidents of patients coming to harm as a result of having an epidural blood patch procedure, there may be an issue of whether this treatment was required ...

- 15.271 A similar explanation was given to patients. To be clear, the Inquiry Panel was unimpressed and disappointed at the length of time that it took to communicate

properly with patients and their General Practitioners. A large number of patients had been informed that they were due to undergo a blood patch procedure by Dr Watt, only to be informed by the Trust that the procedure had been cancelled with little or no explanation. The Inquiry Panel does understand that this was an evolving situation, but the failure to properly communicate with patients in a prompt manner caused many to suffer genuine distress. It also caused numerous complaints to be made, some of which were unfairly directed at Dr Peukert who had stepped into the breach in December 2016 and who, in the absence of proper communication by the Trust, bore an undue and unfair burden.

14th November 2017:

- 15.272 On 14th November 2017, the Trust sent a further Early Alert update to the Health and Social Care Board, indicating that they did not intend to call an SAI: *“The Directorate has advised that the casenote review is still ongoing with an anticipated completion date of early 2018. An SAI is not considered at this stage.”*

29th November 2017:

- 15.273 Ms Andria Gormley, the Appraisal & Revalidation Co-Ordinator, confirmed that Dr Watt had submitted his appraisal for the years 2014, 2015 and 2016.

20th December 2017:

- 15.274 On 20th December, an update was received by Dr Jack from the Royal College of Physicians on its review of 48 clinical records. Dr Peter Belfield, Medical Director for Invited Service Reviews, stated that the clinical reviewers, with support from the Association of British Neurologists, had completed their review of all medical records and were in the process of bringing together their findings and conclusions. He went on to state:

... In the meantime, based on the preliminary findings we would consider it to be appropriate for the restrictions to remain in place for Dr Watt clinical practice, both in the NHS and privately. Dr Watt’s colleagues should continue to review and manage his patients. In addition to this, we feel that there should be a particular focus on patients on disease modifying therapies for multiple sclerosis, similar to that described of those patients on the waiting list for blood patching ...

15.275 Commenting on the review carried out by Dr McDonnell on those MS patients on second line therapy, Mr Watson raised a query as to what extent Dr McDonnell had issues with the diagnosis and treatment of those patients that he had seen. This was an important question and appears to be the first occasion when someone has in writing queried the issue of harm to patients. Commendably, Mr Watson followed the matter up with Dr Mitchelson on 3 occasions, but the Inquiry has not had sight of any response. Dr Mitchelson has explained that his subsequent actions suggest that he did respond to Mr Watson at that time (albeit verbally) on what Dr McDonnell had concluded.

5th January 2018:

15.276 Dr Mitchelson emailed Mr Watson: *'we are working our way through all the MS patients on 2nd line therapy, but we really haven't touched those on 1st line treatments.'*

11th January 2018:

15.277 A Trust Board Meeting took place on 11th January 2018. Dr Jack and Mrs Owens were both in attendance. The issues surrounding Dr Watt, or in neurology generally, were not mentioned in either the minutes of the meeting or the confidential Trust Board Meeting minutes.

12th January 2018:

15.278 Mr Atkinson indicated in an email concerning the INI 399 complaint that: *"Following review of the complaint response, Bernie Owens feels that this case meets SAI criteria."*

15.279 On the same day, the Health and Social Care Board wrote to the Trust seeking a further Early Alert update. The Trust responded, indicating that they: *"are planning a teleconference with RCP later this month to be updated by them on interim findings, while it is expected that the full report will be available at the end of February/March."*

30th January 2018:

15.280 Mr Watson advised Ms Donnelly, the GMC Employer Liaison Adviser, that the Royal College of Physicians Report was awaited in February/March 2018 but that, in an interim letter, the RCP had confirmed the appropriateness of the current restrictions and the action being taken by the Trust.

1st February 2018:

15.281 Dr Farrell returned to work on this date.

1st March 2018:

15.282 A further Board Meeting took place on 1st March 2018 with both Dr Jack and Mrs Owens present. Again, there was no mention of the issues surrounding Dr Watt in the minutes of the Meeting. The Confidential Board Minutes were recorded in handwriting by Peter Watson due to inclement weather at that time, which had prevented a number of administrative staff attending Belfast Trust headquarters. The notes were subsequently typed up in preparation for the attendance of the Non-Executive Directors before the Inquiry Panel. The following was recorded in the typed note:

Mrs Owens indicated that she would update on a matter from September 2017... The concerns related to a Consultant who had a huge case load in Neurology and also who had a big private practice.” Also note the following from Cathy Jack: “Dr Jack advised that there was suggestion that the doctor was not ensuring appropriate diagnosis before doing the procedure. He was technically competent, and there was no harm that we were aware of from his undertaking the procedure. However, there was a risk with the procedure and the consultant was doing more of the procedures. He was not sticking to the criteria for the procedures. He may have put people through unnecessary procedures with a risk of harm.

12th March 2018:

15.283 On 12th March 2018, the Health & Social Care Board emailed the Trust seeking an update on the Early Alert. The Trust replied on the same day, indicating that the RCP report was expected mid-March. A further reply on 14th March indicated the Trust would provide a further update on receipt of the RCP report.

11th April 2018:

15.284 Dr Jack sent an Early Alert update to the Department of Health outlining that the Trust had received the draft RCP report and intended to formally refer Dr Watt to the GMC. The update indicated: *“Discussions with the PHA and HSCB regarding the required response to the report and the appropriate next steps are ...”*

12th April 2018:

15.285 Mrs Owens gave a confidential briefing to the Trust Board on 12th April 2018. Dr Watt's name was not mentioned. By way of background, Mrs Owens stated that the consultant had a high number of patients on his caseload. In April 2018, it stood at 3064 patients and had previously been as high as 5416 as at November 2017. These patients covered a wide range of neurology practice. The concerns in relation to practice were summarised as follows:

Their clinical performance has been under active management and scrutiny from December 2016.

Concerns were initially brought to our attention by a GP and then by a Consultant Neurologist colleague. These concerns were in one area of his practice, that of epidural blood patching, when there was a diagnosis of headache.

An internal review of this area of his practice was undertaken by a consultant colleague who also had a specialist interest, and was also asked to supervise his practice in this area.

This review questioned the appropriateness of a number of patients on the waiting list for epidural blood patching for a diagnosis of intracranial hypotension. In November 2017 the Trust sent letters to 74 patients and their GP to advise that a review was being undertaken of records of patients attending the neurology service who are awaiting for an epidural blood patch. Whilst there had been no reported incidents of patients coming to harm as a result of having the procedure, there may be an issue of whether the treatment was required. Once the review was completed, we would contact them regarding the outcome.

Further to this, an independent review of 5 cases, by two Consultant Neurologists, was initiated seeking assurance regarding the care provided. The outcome of this review substantiated the concerns with Dr Watt's practice, regarding both diagnosis and treatment of intracranial hypotension and his diagnosis and treatment of multiple sclerosis (MS). The supervision in his practice was therefore extended to MS treatment.

Additional concerns emerged regarding the consultant's record keeping leading to full clinical restriction of his practice in July 17.

15.286 The briefing also dealt with clinical restrictions, which had been in place since December 2016, referred also to service delivery issues and summarised the Royal College of Physicians review. It was noted that the draft report was received by the Trust for a factual accuracy check on 20th March 2018. The briefing then gave the draft report's conclusions, which are set out below:

1. The consultant's practice is unsatisfactory in a number of areas.
2. The consultant is underperforming in several domains of his practice representing a significant risk to patients and the Trust's reputation –
 - Careful diagnosis
 - Rational management
 - Openness to the opinions of others
3. Some aspects of the unsatisfactory practice are an immediate concern for patient safety and these cases are to be urgently reviewed by the Trust (some are the index cases).

They have outlined 10 recommendations, which include the following requiring immediate and short term action:-

1. Trust should further discuss this case with NCAS and/or GMC Liaison Advisor, which may lead to formal referral.
2. Full clinical restrictions should remain in place.
3. Trust to communicate with Responsible Officer of private organisations where the consultant works.
4. Trust undertakes further scrutiny of the consultant's practice in 3 specific areas –
 - Epidural blood patching
 - Multiple Sclerosis
 - Epilepsy
5. In cases deemed unsatisfactory, the Trust to communicate with those patients with respect to the care they received.
6. Risk stratify the remainder of the consultant's outpatients and systematically ensure their review.

An action plan is being developed to cover all recommendations.

16th April 2018:

15.287 The draft report from the Royal College of Physicians was received on 20th March 2018 was provided to Dr Farrell to read when she attended for the Neurology Call Back Oversight Group meeting. In her evidence Dr Brid Farrell¹⁴ indicated that she:

... went into Cathy Jack's office and I read it ... it made me feel very uncomfortable that there was a significant issue here and a major logistical challenge to get

14 Assistant Director of Service Development Safety & Quality at the Public Health Agency.

these patients reviewed ... I sat in Cathy's office and read it. I'm allowed to read it ... I didn't get to bring it home with me or anything.

16th April 2018:

- 15.288 On 16th April 2018, the Belfast Trust referred Dr Watt to the GMC Fitness to Practice, enclosing the RCP report.
- 15.289 On the same day, the Trust provided a further Early Alert update to the Health & Social Care Board, indicating that *"the Trust do not intend to declare this as an SAI."*
- 15.290 On the same day the inaugural meeting of the Neurology Call Back Oversight Group took place. The attendees included the following:

Attendees:	
Cathy Jack, Dep Chief Exec	Ian Debois, HSCB
Bernie Owens, Director	Brid Farrell, PHA
Peter Watson, Med Director's Office	Bronagh Dalzell, Corporate Communications
Mark Mitchelson, Chair of Division	Jennifer Thompson, Planning and Perf
Frank Young, Co-Director	Caroline Parkes, OHD
Gerry Atkinson, Service Manager	Michelle Toner, Planning/Contracts
Clare Lundy, ASM	Gillian Allen, Planning/Contracts
Tracey Magowan, Neurological Care Co-Ordinator	Julie McGimpsey, Health Records
Paul McBride, Medical Records	
Dr John Craig, Clinical Director	

- 15.291 The meeting covered the scoping of the look-back exercise, securing adequate capacity, a communication plan, and call back arrangements. A further meeting was arranged for 24th April. Each meeting of the oversight group generated an action timetable.

19th April 2018:

- 15.292 On 19th April 2018, Dr Jack wrote to Dr Belfield thanking him for the draft report and making a number of, what Dr Jack referred to as, minimal comments on the content. It was confirmed that the draft report had been shared with the GMC. Dr Watt had already been referred to the GMC by Dr Jack on 16th April 2018.

24th April 2018:

- 15.293 A further meeting of the Oversight Group took place on 24th April 2018. It was recorded that on 24th April 2018, Dr Craig, Dr Mitchelson and Mr Young met the consultant neurologist team to discuss the look-back exercise. A number of queries and concerns were raised including *inter alia*: (i) unsustainable and unsafe practice for themselves and patients in the look back exercise; (ii) that the look back exercise should be carried out by an external body; and (iii) not dealing with the medical needs of the patient while completing the 3 questions set by the Royal College of Physicians.
- 15.294 On the same day, Mr Watson from the Medical Director's Office sought from Rachel Maxwell, a senior manager in the Complaints Department of the Belfast Trust, a complaint history for Dr Watt. The complaints commenced in 2010 and the last complaint was received in January 2018. In total there were 39 complaints, 27 of which were graded low, 8 graded medium and 4 were ungraded. The data does not appear to have been analysed in any depth at the time.

26th April 2018:

- 15.295 The final report of the Royal College of Physicians was received on 26th April 2018. An SAI notification was sent to the Health & Social Care Board on 27th April by Brian Irwin, on behalf of the Risk & Governance Department. The SAI notification form described the incident as follows:

In February 2017, BHSCCT submitted an Early Alert to DHSSPS (BHSCCT/EA/17/05) regarding concerns having been raised in relation to the practice of a Consultant Neurologist (employed by BHSCCT) in relation to 5 patients. The BHSCCT then initiated an independent review by the Royal College of Physicians (RCP).

The Trust received the final report from the Royal College of Physicians on 26 April 18. In light of the report it is the Trust's intention to undertake a call back exercise to review the care of patients within this Consultants active caseload. This exercise will commence on Tuesday 1 May 2018. The call back involves 2571 patients. An advice line will be set up together with a separate contact point identified for any GP queries.

All patients will be reviewed in a twelve-week period between May and July 2018. Additional capacity has also been created to ensure there is no impact on our current core capacity and therefore no detriment to patients.

15.296 When asked by the Inquiry whether the SAI should have been called at an earlier point Mr Young, in oral evidence on 18th June 2019, stated:

Again, in hindsight, yes, probably. We should have been looking at that earlier.

15.297 In evidence on 4th November 2019, Dr Brid Farrell from the Public Health Agency agreed:

Should it have been – could it have been – declared earlier? And the answer is yes ... So, it could have been declared earlier ... based on the criteria used in the regional policy, I think you could have called it as an SAI. Certainly, I've seen SAIs called for less. Would that have made a difference in terms of the timing of the patient recall? I don't know.

15.298 In an exchange with Professor Mascie-Taylor, Dr Farrell further stated:

Professor Mascie-Taylor: So, that you could argue that December '16 was the right date for the SAI?

Dr Farrell: You could argue, yes.

Professor Mascie-Taylor: Yes? Are you happy with that? I'm not trying to put --. I'm genuinely exploring this with you, because I struggle with it myself.

Dr Farrell: OK. In terms of the definition as described in the procedures, yes ... But equally, in terms of the Maintaining High Professional Standards, you need to ensure that your – whatever response you take is proportionate to the scale of the problem identified.

15.299 During this period, the neurology oversight meeting involving the individuals listed at paragraph 288 above was taking place several times per week. Detailed minutes of the meetings and actions following the meetings have been provided to the Inquiry.

27th April 2018:

15.300 An SAI was called on 27th April 2018.

15.301 An Oversight Group – Neurology Call Back meeting took place on 27th April 2018. Dr Adrian Mairs, who had recently taken over as acting Director of Public Health on 1st March 2018, was in attendance. The minutes¹⁵ note the following:

Adrian asked do we know the magnitude of harm? Peter Watson confirmed

¹⁵ In a written statement to the Inquiry dated 2nd November 2021, Mr Watson believed that the Minutes of the Meeting were not accurate pointing out, inter alia, that Dr Jack had wrong been recorded as being in attendance and that he was incorrectly recorded as Medical Director. He opined that it was more likely Dr Maris's magnitude of harm question was related as the reason for the large patient recall.

that RCP reviewed 48 patient records and supported our approach to review all patients.

Adrian Mairs asked the question of Dr John Craig of level of risk/harm to patients taking DMT? Dr Craig confirmed that Beta-Interferons are very low risk. Tysabri and Lemtrada would have more long-term risks. He also stated some immunotherapies can be life threatening, but more are very low. Dr Craig stated it would be hard to quantify and define the numbers of patients affected until the review has taken place.

15.302 In oral evidence on 4th November 2019, Dr Mairs was asked about his attendance at this meeting:

I think I was probably trying to get a handle on the nature and the scope of this. I mean, this, at that meeting --. That was, as far as I can recall, as far as I can find out from looking through my records, I think that was the only meeting of that particular group that I went to. Because prior to that, Brid Farrell had been going, and subsequent to that, Brid Farrell went to that meeting. I went to that meeting that day because I had been asked at a meeting that I was at that morning by CMO if I would provide him, the Department, with assurance as to the exercise that was being – the recall exercise that was being undertaken by Belfast Trust. So, he asked me verbally for that assurance, to provide him with that assurance, and for me and Miriam to do that jointly, Board and Agency. So, that was that morning. I think it was at coffee just before the meeting started at 10 o'clock. And then I knew there was the --. Because I'd been engaging with Brid, obviously, about the recall exercise, I knew that there was that meeting in the afternoon, then, at the Trust: the meeting for which you have got the minutes. I also knew, from talking to Brid, she was unable to go to that particular meeting. So, I went, partly to go in her place to make sure PHA was there, but also really as more of an in-depth fact-finding for myself, because I knew I had been asked earlier that day to provide this assurance to CMO and the Department as to the process and the plans that the Belfast Trust had for their recall exercise.

15.303 Professor Mascie-Taylor sought further detail around this assurance. Dr Mairs told the Inquiry Panel:

Well, he asked me to provide assurance in relation to the way that the Belfast Trust was planning the recall, and the way I did that – the way that we did it, Miriam and myself – was through reference to some 2007 guidance, the extant guidance that was available at the time. I had been sent a copy of that. I think it was the day before. I was copied into an email with that guidance on it, because that is, in fact, what the Belfast Trust had been using as their template.

The other thing is that the process was just about to go live because the letters were to be sent out to arrive with people on the 1st of May, so this was – we

were asked this on the Friday, with the process due to go live on the Tuesday, with the letters to go out on the Monday.

Well, let me say, we were concerned at the nature of the task we were asked, because, as you will know, to provide assurance about things is very, very difficult and to provide assurance about something as complex as this is difficult. So, we – I suppose, we tried to choose our words carefully.

15.304 Dr Mairs told the Inquiry Panel that a response was provided to the Chief Medical Officer by email on Saturday 28th April 2018:

In terms of providing assurances that the Trust is adhering to expected best practice, my initial assessment is that due process is being followed (with the expected rigour and attention to detail). However, I can assure you that Board and PHA staff will remain engaged with the Review process to monitor performance (of the Review) and ensure that patient safety and any potential public health issues are fully addressed. The planning process, and arrangements for conducting the look back, have been, and are, in keeping with the guidance and appear to be appropriate and robust. The look back exercise will not impact adversely on those patients currently on the waiting list for neurology or under review i.e. the look back exercise involves the provision of additional capacity. It should be noted that we have not received the final Royal College of Physicians report on this issue... PHA/HSCB officers will personally remain engaged with the Review process. We will ensure that the Trust is diligent in terms of meeting its obligations, not only in terms of completing the Review, but to ensure that all patients are provided, where required, with appropriate care (in particular where any harm or adverse consequences become apparent). We will also endeavour to identify where any potential lessons can be identified to improve patient/systems of care within the Trust.

15.305 The Assurance statement of 28th April stated:

You will be aware of the ongoing Look Back exercise being undertaken by Belfast Trust to examine the care of a considerable number of patients managed by Dr A, consultant neurologist. This first came to our attention as an Early Alert on the 13 Feb 2017, initially as a concern regarding the care of 5 patients. The Trust has now formally notified the PHA/HSCB that this is a SAI. While the final figure is to be confirmed, the Review cohort encompasses about 3198 individual patients.

The BHSCCT has been following the extant guidance (A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises). This was issued under cover of HSS(SQSD) 18/2007.

In terms of providing assurances that the Trust is adhering to expected best practice, my initial assessment is that due process is being followed (with the expected rigour and attention to detail). However, I can assure you that Board and PHA staff will remain engaged with the Review process to monitor performance (of the Review) and ensure that patient safety and any potential public health issues are fully addressed.

The planning process, and arrangements for conducting the look back, have been, and are, in keeping with the guidance and appear to be appropriate and robust. The look back exercise will not impact adversely on those patients currently on the waiting list for neurology or under review i.e. the look back exercise involves the provision of additional capacity.

It should be noted that we have not received the final Royal College of Physicians report on this issue.

15.306 Dr Craig, in his evidence to the Inquiry Panel on 5th November 2020, noted the contrast between the early stages of the problem emerging and the later stages when it was decided to initiate the recall. He highlighted the role of Mrs Owens in assembling the right people within the Trust and getting administrative staff to contact over 2500 people and arrange appointments for each of them. Referring to the Belfast Trust and its response, Dr Craig stated:

It was extremely impressive in terms of you got a sense of the size, the breadth, the scope of the place, and the number of people who were out there, from the head of communications to those people who were in the administrative tasks, records, and various things, who really we called together at very, very short notice, not just to manage the actual recall process going forward, but to manage everything that was around that in terms of the interactions of the Department, the media, etc, etc. That bit was extremely impressive. The meetings they we were having from April on, and you will have seen those, sometimes there's 20 people around the table. That obviously wasn't what was happening earlier on, but we knew at that stage we had an ultimatum, a deadline. The letters were landing on people's front door mats on 1st May. I think it was 1st May 2018. Clearly the system had to be up to speed. Bernie was really, certainly it seemed to me, and clearly I was at a lot of those meetings, you can see they happened quite frequently; Monday, Wednesday and Friday. Some of them I can't get to because of clinics, but I am a lot of them. There's a lot of people around the table and the entirety of the system is really very much brought together.

DISCUSSION FOR THE PERIOD JULY 2017 – APRIL 2018

- 15.307 The fact that Dr Watt was not in clinical practice since 27th June 2017, and the RCP had been commissioned to carry out a full case-note review in August 2017, could lead one to the conclusion that the situation was effectively under control during this time. There is no doubt that at certain points and, in particular, from October 2017 and later in April 2018, a significant number of Trust resources were focused on the problems that may arise and the complications of, what was at the time, the largest ever patient recall in Northern Ireland. The Inquiry Panel notes the approbation of the restrictions, which were in place by the Royal College of Physicians in its correspondence of 20th December 2017. The RCP's suggested focus on patients on DMTs for multiple sclerosis mirrored the approach that had been taken at a much earlier stage by the Trust. In the view of the Inquiry Panel, this was evidence that the risk stratification carried out by Dr Craig and Dr McDonnell was well judged and appropriate.
- 15.308 Nevertheless, there remained aspects of communication, particularly with patients, which were suboptimal, even during this period. The importance of communicating with patients who had been expecting a blood patch procedure was highlighted as far back as February 2017 by Mr Atkinson. The fact that communication with patients on this issue did not occur until 8th November, ensured that many patients were kept in the dark and could not understand what was happening. This put inordinate pressure on Dr Watt's secretary and led to a plethora of avoidable complaints.
- 15.309 The Inquiry Panel fully understands that, given the size of Dr Watt's practice, his full restriction from clinical duties was always going to put additional and significant pressures on an already stretched system. Risk stratification, in such circumstances, was critical and initiatives, especially by MS consultants, were carried out with great dedication and commitment. Even though patients who were on second line DMTs were all assessed and able to consult with a specialist neurologist, it appears to the Inquiry Panel that the communication with consultant colleagues was too focused on a concern for confidentiality. Operating on a restrictive "need to know" basis ensured that many neurology consultants were unaware of the scale of the problem.
- 15.310 A further consequence of only partial information being available to other consultant colleagues was that data on misdiagnosis and patterns of practice was not collated during this period in any systematic way. The evidence to the Inquiry Panel is that MS consultants began to notice concerning patterns when they were reviewing urgent cases after Dr Watt was fully clinically restricted in July 2017. In some cases,

this had potential significant impact because a patient may have been prescribed the wrong medication or given a diagnosis, which was incorrect. This obviously raises questions about whether ultimate outcomes would have been improved had misdiagnosis been discovered at an earlier stage. This is, however, outside the Inquiry Terms of Reference.

15.311 The reason for poor communication was often influenced by a concern to maintain confidentiality. This issue has been discussed at greater length in the Medical Culture chapter, but, once again, the Inquiry Panel notes with concern that the priority seems to have been on maintaining confidentiality, rather than on ensuring patient safety. It is the case that the MHPS process does contain the following confidentiality provision at Section 39:

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

15.312 It is of note that the focus of this provision within MHPS is to try and avoid the name of the practitioner being released to the Press. It is permissible to state that an investigation is underway. The Inquiry Panel notes that this was not confirmed by the Trust until April 2018. This approach ensured that employees, such as Dr Watt's secretary, and other administrative staff, had to field the concerns and anger of patients. There is further evidence that the explanation given to patients who complained was not an adequate or accurate description of what, in fact, was transpiring. In the opinion of the Inquiry Panel, there is a marked difference between commenting in the Press and properly briefing consultant colleagues, who are being asked to take on the caseload of a suspended colleague. The Inquiry Panel believes that, from December 2016, too restrictive a view was taken of what could and could not be said to other consultants, although it is fully accepted that this view was informed by the onerous confidentiality provisions of MHPS. The Inquiry Panel notes that Dr Peukert was placed in an invidious position and was not made aware of the background to the partial restriction. This ultimately resulted in the subordination of patient safety concerns to the overwhelming importance of maintaining confidentiality.

15.313 The Inquiry Panel believes that either the confidentiality provision within MHPS needs interpreted in a manner, which does not undermine patient safety or alternatively, the provision needs re-drafted to ensure that patient safety is paramount.

15.314 This report has set out a wide range of reasons as to why, in the view of the Inquiry Panel, the current managerial model needs to be urgently reviewed. These are again summarised below:

- (i) A reluctance among senior managers to, as they see it, 'interfere' in clinical matters, which they believe is outside their competence. Legitimate management concerns are, therefore, too easily conflated with clinical issues and regarded as off limits.
- (ii) The medical tier of management at Clinical Director and Clinical Lead level is focused on representing the interests of their department and has a flawed understanding of their role in the management structure.
- (iii) The Chief Executive is accountable to the Trust Board for patient safety and relies presently to a great extent on the Medical Director for reassurance on patient safety. The Board needs to be configured in such a manner, that allows for a greater focus by Board members on patient safety concerns.
- (iv) The Medical Director is overseeing thousands of doctors and has onerous statutory responsibilities on behalf of the medical regulator (GMC). It is unrealistic to expect a Medical Director to be across all patient safety concerns in the absence of full co-operation from each part of the system.
- (v) The complaints system, as presently structured, does not act as a red flag, and the information it collates is stored in a format, which inhibits proper analysis by medical professionals who have the competence to evaluate the information.
- (vi) Effective action requires the right information to get to the right person at the right time. Too often, the relevant information is retained in an administrative silo, or a doctor has carried out their own investigation and failed to raise concerns, because his or her own threshold for action has not been reached or they are not personally satisfied that there is a sufficient cause for concern. Consequently, opportunities for pattern recognition or triangulating information are lost.
- (vii) In the current medical culture, as represented in Neurology within the Belfast Trust, patient safety as the paramount concern in the management system remains in the domain of ideal rather than as a practical reality. This contrasts with the position, when a doctor is dealing with a particular patient, the vocational approach of the medical profession is to the fore and, as stated elsewhere in the report, public regard for doctors remains extremely high.

COMMUNICATION WITHIN THE TRUST

- 15.315 On 10th September 2019 the Inquiry Panel heard evidence from non-executive directors of the Belfast Trust Board, having already met with both the Chief Executive at the time, Mr Martin Dillon and the Chairman of the Trust, Mr Peter McNaney. The delegation on 10th September 2019 was led by the Vice Chairman Professor Martin Bradley and included Professor Anne Jones, Ms Anne O'Reilly, Mr Gordon Smith, Chair of the Audit Committee, Dr Patrick Loughran, Professor David Jones, Ms Miriam Karp, who led on the issue of doctors' performance, and Ms Nuala McKeagney.
- 15.316 The evidence of the Non-Executive Directors highlighted the importance of the challenge function and described good working relationships between the executive team and the non-executive directors as outlined below:

Professor Bradley: I think that our role, certainly, as non-executive directors, is a role that we do take very seriously. I think that we're very conscious of the size of this Trust. I think that, really, our responsibility is to work with our executive colleagues in setting a strategy for the Trust, ensuring that it is as safe as we can make it, ensuring that we hold the executive to account and also really getting to know the organisation on an ongoing basis ... through those mechanisms, through those controlled assurances, we are able, I think, to ask more intelligent questions and, indeed, to dig down a little bit more deeply.

Ms Karp: I suppose what I would say is that, since we were appointed, we've been on a journey, along with the executive, to improve the safety and quality of this organization. We don't take things as read. "trust and check", as the chair always says and Martin, in his gentler way, always says when we're told something, and we know that, that delving beneath, that looking for the evidence, looking for the data, that triangulation, that ability to get outside the meeting and go and knock on people's doors and say, "You said that. I'm not sure of that. Help me to understand that". As a board, I think, we exercise that challenge function well. That's my opinion.

Dr Loughran: I would also add that I think that the executive team has responded very well to that development of hearing more challenge, of being asked for more information. They have been ready and, by and large, able to provide that information. There's no resistance; there's no secrecy; there's no division between the executive and the non-executive. It's not a divided conversation. I have a very strong sense that we work well together, and they are ready with the answers or are prepared to go and look for them as we ask them.

Ms Karp: It's not always comfortable. You know, when you're exercising that challenge function, there's a rub; sometimes we're pushing against things

And I think it's appropriate that it isn't always easy. Paddy's right: we get the information we want and need, but it isn't always easy. I think, when it becomes too comfortable, then, perhaps, we've lost the challenge function.

Professor Bradley: I think it's fair to say that we have worked very hard to become a corporate board, and, I think, we have also begun to acknowledge that we're in this together and not only will the executives be called to account but we will also be called to account.

15.317 The Inquiry Panel recognises that, in overseeing a staff of over 22,000 and a budget of £1.4 billion, the ability of the Trust Board to be aware of the precise details of what is going on with doctors in difficulty is, for the most part, not realistic.

15.318 In Dr Watt's case the Board were given an oral briefing on 7th September 2017 by Dr Jack, who informed the Trust Board about concerns she had about a neurologist whose practice was restricted. Ms Karp told the Inquiry Panel:

We were told the doctor had been restricted- and the Doctor had been restricted from December 2016, actually and those restrictions had been reviewed and strengthened until he'd been totally restricted on 22nd July. So from a patient safety point of view, there was no further risk.

15.319 On 1st March 2018 Mrs Owens gave the Board a further oral briefing that they were expecting a review from the Royal College of Physicians on Dr Watt's practice; that there has been an Early Alert to the Department and that Dr Jack had been liaising with Public Health Agency.

15.320 On 11th April 2018 a confidential briefing was given to the Board in a written paper prepared by Mrs Owens. There were a number of inaccuracies in the written paper and in particular in the 'Background' section. The paper stated:

Concerns were initially brought to our attention by a GP and then by a Consultant Neurologist colleague. These concerns were in one area of practice, that of epidural blood patching, when there was a diagnosis of headache

The paper failed to point out that the initial concerns related to MS and epilepsy, not epidural blood patching, which emerged some weeks later, but nevertheless the paper did broadly summarise the finding of the RCP report and set out the next steps to be taken.

15.321 In considering the internal communication within the Belfast Trust during this time the Inquiry panel makes 3 observations:

- (i) The Department were informed by way of Early Alert in February 2017 of potential problems. This, in turn, led to the involvement of the Public

Health Agency. The reason for the Early Alert is that the Minister is not surprised by a development of which he or she is not aware. It seems incongruous that similar considerations did not seem to apply to the Trust Board, who were not informed until September 2017 and did not receive a written briefing until the 12th April 2018¹⁶.

- (ii) It would have been more appropriate for Dr Jack and Mrs Owens to give a written rather than an oral briefing to the Board in both September 2017 and March 2018. This is a recognised procedure in the Board and indeed was utilised in the April 2018 briefing. The difficulty with oral briefings is that there are no minutes, and as demonstrated by the non-executive directors, during their appearance before the Inquiry panel in September 2019, what was said previously must be pieced together and carried out without any contemporaneous note.
- (iii) Problems with accuracy in an oral briefing are highlighted by the fact that even the written paper presented in April 2018 was inaccurate in several material respects. Although this was not ultimately misleading, the importance of understanding the history of the matter accurately is essential if a Board is to properly operate a challenge function.

COMMUNICATION WITH THE PUBLIC HEALTH AGENCY (PHA)

15.322 The PHA provides the professional input to the Health and Social Care Board, who are tasked with commissioning of healthcare services, performance improvement and resource management. In effect, the PHA and the Health and Social Care Board operate as a single body. The definition of an SAI is set out in the relevant policy as *“any event or circumstance that could have, or did, lead to harm, loss or damage to people, property, environment or reputation”*. In her evidence to the Inquiry Panel of 4th November 2019, Dr Brid Farrell, designated Review Officer within the PHA recognised that the index cases identified in December 2016 may well have fulfilled the criteria for an SAI to be called. Dr Farrell, however, recognised that the commissioning of an RCP report and the Gray/McConville reports was also a means by which the Trust could seek to reassure the PHA that the question of potential harm was being addressed.

15.323 Dr Farrell also understood that there was a tension between the demands of the Maintaining High Professional Standards (“MHPS”) and the obligation of ensuring patient safety:

¹⁶ In a written response of 5th May 2022, the Belfast Trust pointed out that this issue has now been addressed through the provision of copies of all early alert notifications to board members as they are made, and is further an agenda item at the confidential board meetings for discussion in respect of anything arising. The Inquiry Panel welcomes this development.

Dr Farrell: But equally, in terms of the Maintaining High Professional Standards, you need to ensure that your — whatever response you take is proportionate to the scale of the problem identified.

Professor Mascie-Taylor: Precisely.

Dr Farrell: Uh-huh.

Professor Mascie-Taylor: So, these are two totally different processes?

Dr Farrell: Yes.

Professor Mascie-Taylor: Yes? One is purely about the behaviour of doctors and the other is about the behaviour of the system.

- 15.324 As is evidenced by the interactions between Dr Jack and Dr Farrell from the PHA, there was ongoing contact with the PHA by the Belfast Trust and, in particular, Dr Jack. Dr Farrell as the Designated Review Officer (“DRO”) became aware of a problem when an Early Alert was received from the Trust in February 2017¹⁷. At that point, 6 index cases were notified and the Trust had initiated an independent review of the 6 cases by two consultant neurologists¹⁸. The Alert had indicated that the Trust was taking interim steps to ensure that patient safety was protected. Dr Farrell was not aware, at that point, that this involved a partial restriction on Dr Watt diagnosing cases of SIH.
- 15.325 Formal updates were received, which did not amplify earlier information and, in July 2017, Dr Farrell spoke with Dr Jack and the correspondence further restricting Dr Watt was shared with her. Dr Farrell was off work from October 2017 to February 2018, during which time she would not have had any further contact with Dr Jack. She arranged a meeting with Dr Jack in April 2018 and, at that point, got involved in the Patient Review Call back. An SAI was declared in respect of concerns about Dr Watt’s practice in April 2018 shortly before the patient recall. Dr Farrell was given an opportunity to read the draft RCP report on the 48 index cases in April 2018 in Dr Jack’s office but was not permitted to take a copy. The concerns raised again at that time were about confidentiality and the requirements of the MHPS process.
- 15.326 The Inquiry Panel explored in some depth with Dr Farrell when she gave oral evidence on 4th November 2019 as to whether an SAI should have been called earlier, given that the criteria were met as far back as December 2016. The Inquiry Panel has concluded that a level 3 SAI investigation, which involved an independent

¹⁷ See the evidence of Dr Farrell at paragraph 71 above.

¹⁸ This refers to the reports prepared by Dr Gray and Dr McConville. The 5 cases should, in fact, have been 6, but one case seems to have been mislaid for a period and was not referred to in the Early Alert.

assessment, would not have been of any great advantage, given that Dr Jack had already initiated an independent reviews, initially by Dr Gray and Dr McConville and then later by the Royal College of Physicians. The Inquiry Panel also notes the delays in the INI 399 case which did involve the calling of an SAI and queries whether the calling of an SAI in Dr Watt's case would actually have impeded the investigations initiated.

- 15.327 Of greater interest to the Inquiry Panel, however, was the issue of communication between the Trust and Dr Farrell, as the Designated Review Officer, in the period between February 2017 and April 2018. During that time, communication was formal and somewhat limited. The Trust certainly sought to reassure the PHA that they had the matter in hand and were taking various steps. Given, however, that it was ultimately the role of the Director of Public Health to reassure the Chief Medical Officer on the steps that had been taken, closer co-operation and the sharing of information would have strengthened decision-making.
- 15.328 The intervention by Dr Mairs on 27th April 2018, when he asked the critical question at the Oversight Group for the Neurology call back of whether the magnitude of harm had been assessed, was a question that could have been raised earlier if the PHA had been better informed or, in the alternative, had been more proactive in querying the information that they had been given.
- 15.329 Dr Mairs, who had recently taken over as the Director of Public Health in March 2018 was being asked to assure the Chief Medical Officer in April 2018 that the Belfast Trust was adhering to expected best practice in respect of the recall process. The Inquiry Panel believes that Dr Farrell should have been briefed more fully and given a copy of the report (as opposed to being allowed to read the report if the PHA was being asked to give such an assurance. The impression given from the documentation provided is that the Trust was fulfilling its obligation to the PHA as opposed to bringing them properly into the discussion at an earlier stage.
- 15.330 In March/April 2017, the extent of Dr Peukert's disagreement with Dr Watt on his diagnosis of SIH became known. In June 2017, the Gray/McConville reports were furnished, and further restrictions were imposed in respect of multiple sclerosis. These were both examples of where the potential magnitude for harm needed to be reassessed. The Inquiry Panel accepts that the Trust and, in particular, Dr Jack were being proactive, both in terms of the commissioning of the RCP report and the restrictions that were imposed upon Dr Watt in July 2017. Nevertheless, given the role of the PHA, a broader discussion about sanction and harm with the PHA would have been helpful.

- 15.331 Similar observations can be made with regard to the Early Alert system. The reason for introducing this system is commendable. No Minister of Health or Permanent Secretary in the Department of Health wants to hear of a crisis in the Health Service at the last minute. In this instance, an Early Alert notification was made timeously in February 2017. This was followed up by regular monthly updates to the Department and the PHA. Once again, however, the information shared was limited and, in the view of the Inquiry Panel, the impression given by reference to concerns about the practice of a consultant neurologist and a review of 5 index cases is far removed from the overall impact of the RCP report in April 2018. Mr Young candidly informed the Inquiry Panel that he was aware of information leaking on previous occasions to the Press following an Early Alert. This, once again, raised the spectre of an over concern about confidentiality, further reinforcing a silo mentality within the Trust. Information given was guarded and updates to the Department were laconic and contained only basic information. If the system is meant to inform the Department in the manner intended, then updates should be more comprehensive.
- 15.332 The Inquiry Panel accepts Dr Jack’s observation that confidentiality is a part of the MHPS process and, further, that non-compliance with the process can sometimes lead to legal challenge and difficulties with the medical defence organisations. Nevertheless, the Inquiry Panel considers that the circles of knowledge need to expand, and patient safety given a paramount importance at every stage. In the Panel’s view, there were too many incidences where concern about sharing information led to opportunities and patterns of clinical behaviour being missed.

Conclusions and Findings:

- 15.333 In any assessment of the period between November 2016 and the announcement of a patient recall in May 2018, the Inquiry Panel acknowledges that many of the steps taken by the Trust were commendable. In particular, the following steps were appropriate and played a key role in the developing understanding of the Trust:
- (i) **The decisive action of Dr Jack in introducing a restriction involving Dr Watt’s diagnosis of SIH at a point where her own knowledge was limited.**
 - (ii) **The action of Dr Craig in raising immediately with Dr Jack a concern about Dr Watt’s diagnosis SIH on 12th December 2016, which led to the partial restriction being imposed by Dr Jack.**
 - (iii) **The appointment by Dr Craig of Dr Peukert to review any future diagnosis of SIH to be carried out by Dr Watt. The Excel spreadsheet**

devised and initiated by Dr Peukert was a critical collation of information that informed the Trust for the first time of the scale of the problem.

- (iv) The recommendation by Dr Craig that Dr Gray and Dr McConville should be asked to review the 6 index cases. Despite the unacceptable delay in obtaining medical notes and records, the review was carried out effectively and led to further restrictions being imposed.
- (v) The decision by Dr Jack to ask the Royal College of Physicians to review a larger sample of 48 case histories was an effective and prescient method of assessing the true scale of the potential problem. It was this report received in April 2018 that laid the foundation for the decision by the Belfast Trust to announce a significant patient recall. This was the single most important decision taken in the whole process and the actions of the Medical Director were rightly commended by the Royal College of Physicians.
- (vi) At a time when Neurology was under intense pressure with ever-increasing waiting lists and the absence of Dr Watt (who had treated and reviewed perhaps the greatest number of patients), the stratification of those patients at the greatest risk from inappropriate treatment, overseen by Dr Craig and Dr McDonnell, was well-judged and appropriate.
- (vii) The co-ordinated approach of the Neurology Oversight Committee, which commenced in October 2017, ensured that the key personnel communicated and prepared well for the patient recall.

15.334 Having carefully scrutinised the actions of the Trust throughout the relevant period between the raising of the index cases and the announcement of the recall, the Inquiry Panel would also point to a number of failings which undermined the effectiveness of the Trust response.

15.335 The most salient and specific issues regarding failings during this period can be summarised as follows:

- (i) The fact that the Trust did not appreciate that there was much in Dr Watt's clinical background that was highly relevant to the issues that emerged in November 2016, was a serious failing. The inadequate analysis of the Trust was contributed to by other organisations. This included the General Medical Council and the Ulster Independent Clinic.
- (ii) The decision taken at an early stage to keep the circle of knowledge as tight as possible led to confusion at times. In particular, the decision not to brief the Clinical Lead, Dr McDonnell, though taken on good faith grounds, prevented Dr Craig from receiving critical input.

- (iii) If Dr Jack had been aware of Dr Gray's assessment, and Dr McDonnell's assessment of one of the index cases involving MS, then it is inevitable that there would have been a much more careful examination of the MS cases at that stage. In the view of the Inquiry Panel, it is likely that this would have resulted in restrictions being imposed on Dr Watt's MS practice in December 2016. The position, however, was that both Dr Craig and Dr Jack were unaware of Dr Gray's views and had not consulted with Dr McDonnell, who had treated the same patient and come to a different view on diagnosis than Dr Watt. While the decision to obtain an independent view from Dr Gray and Dr McConville was appropriate, the time taken to obtain the medical notes and records resulted in an unacceptable delay. It would have been entirely appropriate, in the view of the Inquiry Panel, for Dr Craig to discuss the case with Dr McDonnell, in order to properly advise the Medical Director.
- (iv) Despite the assiduousness and efforts of Mr Watson, there was a confusion of roles and an unacceptable delay in obtaining the relevant notes and records for Dr Gray and Dr McConville to review. When the notes and records were eventually obtained, the review was completed promptly. It was not until June 2017 that the Gray/McConville reports could be reviewed. Clarity about who was responsible to ensure that the records were obtained was lost, particularly when Dr Jack directed that Dr Craig should not be involved in the process, as he himself had raised a case of concern regarding SIH.
- (v) The confusion that emerged in the implementation of the partial restriction ensured that an appreciable number of patients underwent unnecessary blood patch procedures.
- (vi) The failure to communicate with patients for many months was unacceptable and led to patients being distressed and uninformed. This placed an intolerable burden not only on Dr Watt's secretary, but also on Dr Peukert, who was subject to unfair patient complaint, based on a misunderstanding of the true situation.
- (vii) The first Excel spreadsheet produced by Dr Peukert in mid-January 2017 was not passed quickly enough to Dr Jack by Mr Young and to a lesser extent, Dr Craig who was absent at the material time. This was the first real indication that there was a serious and potentially widespread problem with blood patch procedures far beyond earlier expectations.
- (viii) The failure by Mr Young to escalate the concerns of Dr Stephen Hunt regarding blood patching to the Medical Director meant that blood patch treatments continued for several months beyond March 2017. The Inquiry Panel is satisfied that, had Dr Jack been informed, she would have

prevented all blood patch treatments by Dr Watt and may have decided at that stage to fully restrict his clinical practice.

- (ix) Dr Peukert raised with Dr Craig and Dr McDonnell, at the end of April 2017, a concern about a patient who had been diagnosed by Dr Watt with multiple sclerosis and had been prescribed *Tecfidera*. Dr Craig, who was fully aware of the issues around multiple sclerosis should have immediately escalated this case to the Medical Director; although the Inquiry Panel notes that the tests ordered by Dr McDonnell were completed at the same time as restrictions were placed on Dr Watt's MS practice at the beginning of June 2017.
- (x) The Inquiry Panel notes that Dr Mitchelson, the newly appointed Co-Chair of the Division on the medical side, was immediately drawn into the decision-making, even though his managerial experience and knowledge of what had transpired in November 2016 was limited. The Inquiry Panel believes that this may have contributed, in part, to his reluctance to pass on to Dr Watt the letter from Dr Jack on 23rd June 2017 and to defer the matter for further enquiry. As events unfolded, this did not have any material bearing on the subsequent actions taken, or permit Dr Watt to resume practice, given the fact that he was due to attend a course the following week and Dr Jack and Mrs Owens met with Dr Watt on 27th June 2017.
- (xi) The evolving picture could have provoked an in-depth review of Dr Watt's clinical history and complaints profile. This would have revealed, at an early stage, how information was retained in a diffuse and confusing manner. The Northern Trust concern might have been re-visited and reviewed by Dr Jack. Such an exercise may have begun to alter the narrative that became embedded in the thinking of the key personnel that, prior to November 2016, there were no real concerns about Dr Watt.

15.336 A system that places patient safety at its core cannot work effectively unless there is a greater number of people than the Medical Director and her staff, who are more alert to the potential consequences of permitting what may turn out to be aberrant practice to continue unchecked. This series of events also brings into sharp relief the current managerial system, where the culture operating in Neurology does not encourage either escalation or other action. The Inquiry Panel believes that such a view is by no means unique to Neurology, as evidenced by Dr Craig's discussion with other clinical directors at a meeting in June 2019. There is a common understanding that if matters do reach the Medical Director that she has a duty to consider and, if necessary, act, but that obligation appears to be unique to the Medical Director or her office, unless the most egregious and obvious problems become apparent.

15.337 It is this reality, which needs to be at the heart of any response to this report by the Belfast Trust. In this regard it would be incorrect to view the problem as solely in the domain of those, who take on other managerial roles and that the Trust can point to policies in place and job descriptions appended to contracts as their response. In a situation, where the information flowing from other managerial roles on patient safety and colleague concern is negligible, the question needs to be asked as to “Why?” It is only when the answer to that question is properly analysed that the possibility of change emerges.

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Printed in the United Kingdom by Digital Print Services of the Northern Ireland Department of Finance

ISBN 978-1-912313-63-1

