Independent Neurology Inquiry

Corrections

Volume	Chapter	Revised Text	Original Text
1	2	2.117 As per my earlier email, I feel the likelihood of an inquest clarifies things in terms of how we respond to INI 87 parent.	2.117 As per my earlier email, I feel the likelihood of an inquest clarifies things in terms of how we respond to *INI 87* parent.
2	4	4.3 The time period being examined by the Inquiry in this chapter, 2006-2007, spanned the merger of the 6 legacy health trusts into the Belfast Health & Social Care Trust, which was established on 1st August 2006 and became operational from 1st April 2007. It was a time of significant change within the health service in Northern Ireland.	New Paragraph
2	4	4.4 The new Belfast Trust had a budget of £1.1 billion and c. 20,000 staff with 800 career grade doctors when it became operational. It was one of the biggest employers of doctors in the UK. This presented significant challenges in introducing a single system of integrated	New Paragraph

		governance that included professional and clinical governance. Dr Stevens the then Medical Director was working on these issues during 2006 and 2007.	
2	4	4.5 Because of its size, the Belfast Trust had a federated structure comprising services groups, led by a director. Each director was accountable to the Chief Executive for the business of their service group and was supported professionally by an Associate Medical Director, who was a doctor with 50% of their time allocated to management. Dr Stevens noted that within a year of establishing the Belfast Trust, the number of consultants in the leadership roles had increased from one in nine to one in six.	New Paragraph
2	4	4.11 Footnote 2 @ Copy to Jim Morrow – At the time of this complaint, and other events referred to in this and other chapters, Dr Jim Morrow was a Consultant Neurologist and Clinical Lead for Neurology. He was invited to give oral evidence to the Inquiry but on 2nd October 2019 his legal representative sent	4.8 Footnote 2 @ Copy to Jim Morrow – At the time of this complaint, and other events referred to in this and other chapters, Dr Jim Morrow was a Consultant Neurologist and Clinical Lead for Neurology. He was invited to give oral evidence to the Inquiry but on 2nd October 2019 his legal representative sent

			replying correspondence declining the invitation on medical grounds. Medical evidence was also received explaining why Dr Morrow was not fit to give evidence. All references in the report to Dr Morrow have, therefore, had no direct comment or input from Dr Morrow himself.		replying correspondence declining the invitation on medical grounds.
2	4	4.12	He replied "no, not at all but I am sure it happened because you know, we were all at Michael, myself, and Peter Walby, everybody."	4.9	He replied…..
2	4	4.13	Dr McBride confirmed that the note referred to at paragraph 4.11……	4.10	Dr McBride could not recall the specific complaints referred to above, but did confirm that the note referred to at paragraph (???) above was his……
2	4	4.14	Dr McBride's recognition that consistent problems in meeting appraisal and other practice obligations may have been symptomatic of a deeper problem was a question that the Inquiry Panel also reflected upon during the Inquiry. The approach taken by management throughout the relevant period suggested that a dichotomy persisted between	4.11	Dr McBride's recognition that consistent problems in meeting appraisal and other practice obligations may be symptomatic of a deeper problem was a question that the Inquiry Panel also reflected upon during the Inquiry. The approach taken by management throughout the relevant period

		administrative and clinical in relation to Dr Watt, which was never properly considered.	suggested that a dichotomy persisted between administrative and clinical in relation to Dr Watt, which was never properly reflected upon.
2	4	4.16 …. On 5th October 2005, however, the General Medical Council ("GMC") wrote to Dr McBride…..	4.13 ….. In October 2005, however, the General Medical Council ("GMC") wrote to Dr McBride……
2	4	4.17 The GMC letter of 5th October 2005 sought from the Belfast Trust: • Details of any other concerns or previous complaints (if any) regarding Dr Watt's practice. • Any audit findings (or other quality assurance measures), which might indicate problems with Dr Watt's practice. • Any data (e.g. in relation to prescribing patterns), which might indicate poor practice. • Any other information, which may be relevant to inquiries.	4.14 The GMC became involved and in a letter of 5th October 2005 sought details from the Belfast Trust of any other concerns or previous complaints regarding Dr Watt's practice.

2	4	4.20 it is <u>all</u> correct.	4.16 …it is all correct.
2	4	4.20 …addressed in the Division. Other than referring or delegating the matter to Mr Adams, the Inquiry is not aware of any further steps taken by Dr McBride. Mr Adams, in his evidence from 8th January 2020 indicated that he had no recall of this but that he would *"almost certainly have acted on that. I would have seen him [Dr Watt] and I would talk to him. And I would have talked to the other people involved"*. The Inquiry Panel observed that there was no file note of any conversation between Mr Adams and Dr Watt. If there had been such a file note available to the Inquiry, then the issue could have been followed up with Dr McBride as to what further steps (if any) were taken or ought to have been.	4.16 ……addressed in the Division. Find a way to Mr Adams in his evidence from 8th January 2020 indicated that he had no recall of this but that he would *"almost certainly have acted on that I would have seen him [Dr Watt] and I would talk to him. And I would have talked to the other people involved"*. The Inquiry Panel noted that there was no file note of any conversation between Dr Adams and Dr Watt.
2	4	4.21 …… Mr Walby responded to this in some detail on 14th March giving a much more comprehensive and frank summary in relation to INI 403 and INI 405.	4.17 …….. Mr Walby then responded to this in some detail on 14th March giving a much more comprehensive summary in relation to INI 403 and INI 405.
2	4	4.22 GMC correspondence and concerning the same subject matter (INI 406 and INI 407),….	4.18 …GMC correspondence and concerning the same subject matter,….
2	4	4.23 Part of the evidence quoted above from Mr Walby is now known to be incorrect, in light of	4.19 Part of the evidence quoted above from Mr Walby is now known to be incorrect,

		other documents subsequently disclosed, which revealed that Mr Walby was, aware of the INI 406 and INI 407 cases by at least 14th March 2006.	in light of other documents subsequently disclosed, which revealed that Mr Walby was, in fact, aware of the INI 405 and INI 406 cases .
2	4	4.25 The Inquiry Panel accepts that Mr Walby……	4.21 The Inquiry Panel accept that Mr Walby….
2	4	4.26 In his evidence to the Inquiry Panel on 7th November 2019…..	4.22 In his evidence to the Panel on 7th November 2019…..
2	4	4.29 ……Although many blood tests were administered to understand the underlying aetiology….	4.25 … Although many blood tests were done to understand the underlying aetiology…..
2	4	4.30 …. INI 222 subsequently developed dizzy spells associated with a marked drop in heart rate and significant reduction in blood pressure….. ……in addition to clinical issues, summarised in June 2006 as follows:……	4.26…She subsequently developed dizzy spells associated with a marked drop in heart rate and significant reduction in blood pressure….. ……in addition to clinical issues, summarised by INI 222 as follows:…
2	4	4.37 Subsequently, Mr Atkinson, the Service Manager within Neurosciences, wanted to follow up on a number of issues that had not been commented on by Dr Watt.….	4.32 Subsequently, Mr Atkinson, the Service Manager within Neurosciences, wanted to follow up on a number of issues that had not been commented upon by Dr

			Dr Stevens, indicated he may have to intervene and subsequently did become involved.		Watt. …..Dr Stevens, at that time Acting Medical Director, indicated he may have to intervene and subsequently did become involved.
2	4	4.38	At this point the focus moved beyond this particular complaint. Dr Watt had failed to respond to additional questions in relation to the INI 222 complaint and also not completed his appraisal….	4.33	It was at this point that the focus of the complaint shifted. Dr Watt had not just failed to respond to additional questions in relation to the INI 222 complaint but had also not completed his appraisal…
2	4	4.39	On 4th October 2006, Mr Cooke,…..	4.34	On 4th October 2006, Mr Stephen Cooke,….
2	4	4.41	..And to encourage them to point out to them the difficulty of not doing it…..	4.36	And to encourage them to point out to them the difficult of not doing it….
2	4	4.43	The sentiments expressed by Mr Cooke are, in the view…..	4.38	The sentiments expressed by Mr Cooke at this time are, in the view…..
2	4	4.44	On 4th October 2006, Dr Stevens in an email to Mr Adams, Mr Watson, Mr Cooke, Mr Atkinson and Mrs Webb stated: "*if local resolution is not successful we are close to handling Michael down a formal line. He needs to understand this and the implications*". Despite this, Dr Watt still failed to	4.39	On 4th October 2006, Dr Stevens in an email to Mr Watson, Mr Cooke, Mr Atkinson and Mrs Webb stated: "*if local resolution is not successful we are close to handling Michael down a formal line. He needs to understand this and the*

		respond to the complaint as required.	*implications".* Despite this, Dr Watt still failed to respond to the complaint as required. No action was taken at his failure to respond.
2	4	4.45 On 12th December 2006, Mr Adams, Divisional Director,…. There is no file note of this discussion.	4.40 On 12th December 2006, Mr David Adams, Divisional Director,…… There is no file note of this discussion, but no action appeared to have been taken.
2	4	4.46 A meeting was subsequently held between INI 222, family members,…..	4.41 A meeting was subsequently held between INI 222, members of her family,….
2	4	4.47 …Dr Stevens's response stated:…..	4.42 …..Dr Stevens responding stated:…..
2	4	Paragraph removed	4.43 It is not clear to the Inquiry Panel that the matter was resolved or that the issue was actually dealt with appropriately.
2	4	4.55 The formal reply from the Acting Chief Executive, Mrs Deirdre O'Brien, was provided on 9th January 2007. The letter noted that: *"your complaint has been investigated by senior management in the Neurosciences Department with*	4.51 The formal response from the Acting Chief Executive, Kate O'Brien, was provided on 9th January 2007. The letter noted that: *"your complaint has been investigated by senior management in the*

			input from Dr G McDonnell, Dr M Watt, Dr S Hawkins and Dr A Stevens". From the evidence outlined above, it is apparent that Dr Hawkins' involvement with INI 222 and drafting of the letter was minimal.		*Neurosciences Department with input from Dr G McDonnell, Dr M Watt, Dr S Hawkins and Dr A Stevens"*. From the evidence outlined above, it is apparent that Dr Hawkins' involvement with INI 222 and drafting of the response was minimal.
2	4	4.57	Dr Stevens clearly contemplated getting a further view but decided not to do so, leaving the issue unresolved and, as per the above, outlined the two contrary opinions in the final response.	4.53	Dr Stevens clearly contemplated getting a different view but failed to do so, leaving the issue unresolved and, as per the above, simply outlined the two contrary opinions in the final response.
2	4	4.58	Could there be others?"	4.54	… Could there be other similar cases?"
2	4	4.60	The draft omitted any reference to the view of Dr Hawkins that the continued prescription of Beta Interferon was outside the guidelines and this draft reply was then incorporated into a formal letter from the Director of Nursing, Mrs KMD O'Brien in a letter of the 28th June 2005.	4.56	The draft response omitted any reference to the view of Dr Hawkins that the continued prescription of Beta Interferon was outside the guidelines and this draft response was then incorporated into a formal response from the Director of Nursing, Mrs KMD O'Brien in a letter of the 28th June 2005.

2	4	4.66	The question to be investigated was never focused upon by anyone. ……. …….Dr Morrow and Dr Hawkins would have been aware that this issue would need to be considered.	4.62	The question crying out to be investigated was never focused upon by anyone. …… …. Dr Morrow and Dr Hawkins would both have been aware that this issue would need to be carefully considered.
2	4	4.70	Mrs Webb had indicated that she was aware that Dr Morrow…..	4.66	Mrs Webb had discussed the matter with *junior member of staff* and indicated that she was aware that Dr Morrow….
2	4	4.71	Dr Morrow observed that INI 87 had a continuing tendency to seizures…..	4.67	It was noted that INI 87 had a continuing tendency to seizures…..
2	4	4.73	In a letter of 27th October 2006 to the Patient Liaison Manager, he expressed….	4.69	In an email to the Patient Liaison Manager, he expressed…..
2	4	4.76	……and in his correspondence to INI 87's GP, of 12th January 2006, in which he wondered…..	4.72	…….and in his correspondence to INI 87's GP, in which he wondered……
2	4	4.77	This concern is apparent from an email dated 3rd November 2006 from a junior member of staff to Mr Watson, Mr Atkinson, Mr Cooke and Dr Stevens which…..	4.73	This concern is apparent from an email dated 3rd November 2006 from *junior member of staff* to Mr Watson (Divisional Manager), Mr Atkinson (Service Manager), Mr Cooke (Clinical Director)

					and Dr Stevens (Medical Director) which……
2	4	4.78	…..the complaint. The Inquiry Panel noted that on 21st December 2006 Dr Watt wrote to Mr Watson:	4.74	..the complaint. The Inquiry Panel noted that on 12th December 2006 Dr Watt wrote to Mr Watson:
2	4	4.79	… inappropriate in [INI 87] case given that the diagnosis of epilepsy was by no means secure…	4.75	… inappropriate in individual patient's case given that the diagnosis of epilepsy was by no means secure…
2	4	4.84	The notes record that Dr Morrow stated: Attacks look/sound what are epileptic attacks also had pseudoseizures. How much was true epilepsy? Dr Morrow's comments contrast somewhat in tone with his earlier statements to INI 87's General Practitioner and the earlier draft of the response to INI 87's parents	4.80	The notes record that Dr Morrow stated: Attacks look/sound what are epileptic attacks also had pseudoseizures . Dr Morrow's comments contrast in tone with his earlier statements to INI 87's General Practitioner and the early draft of the response to INI 87's parents.
2	4	4.89	On 23rd February …	4.85	On 3rd February…
2	4	4.95	The Inquest also received evidence in the form of a written report dated 19th April 2010 from Professor Dennis Johnston, Consultant	4.90	The Inquest also received evidence from Professor Dennis Johnston, Consultant Physician. Professor Johnston concluded

		Physician. Professor Johnston concluded that the cause of death was a morphine overdose in combination with a number of drugs, which are known to cause respiratory depression.	that the cause of death was a morphine overdose in combination with a number of drugs, which are known to cause respiratory depression.
2	4	4.101 Footnote 5: Email from John Johnston, the solicitor from DLS representing the Belfast Trust, dated 26 May 2020.	4.96 Footnote 5: Email from John Johnston dated 26th May 2020.
2	4	4.102 The correspondence is extensively set out in full: Dear Michael Thank you for attending the meeting with myself and Mr Damian McAlister, Acting Director of HR, on Wednesday 20th December. I am writing to confirm the discussions we had and to outline the steps I require you to take to address the matters that were discussed. At the outset of the meeting I indicated that I wished to discuss the following matters with you: • Consultant Appraisal • CPD • Responding to Complaints	4.97 The correspondence indicated that he had wished to discuss with Dr Watt the following matters: • Consultant appraisal. • CPD. • Responding to complaints. • Responding to medical legal requests. • Ongoing GMC Inquiry.

		• Responding to Medical Legal requests • Ongoing GMC Enquiry I have detailed below the key points discussed and the actions agreed in respect of each. **Consultant Appraisal** You are aware of the requirement to be appraised as detailed in the Departmental Circular HSS (TC8) 11/01, and that a failure to comply may lead to future issues around re-licencing with the GMC. This would of course have significant consequences and impact on your ability to practice as a consultant neurologist. While I am assured that you have now participated in the appraisal process for the first time, I must advise you that participation once in five years is not acceptable and that I will expect you to participate more fully henceforth. I attach for your attention the aforementioned DHSSPS circular and would ask you to familiarise yourself fully with the content. **CPD** It was disappointing to learn that you had not registered with the College for CPD and	

		I would encourage you to take urgent steps to address this. Failure to do so may lead to problems with both the College in terms of re-certification and for future re-licencing with the GMC. It is also a cause for concern for your employer as the college provides a useful assurance role in this respect. **Responding to Complaints and Medical Legal Requests** I highlighted certain patient complaints, to which you had not provided a timely response or that the response provided was deemed insufficient. You indicated that you sometimes found it difficult to translate onto paper what would be deemed a suitable response, but as I advised you in reply the Trust has trained staff who can assist clinicians in developing appropriate responses. There is also a similar concern with requests for medical reports from legal/insurance companies, one of which had led you to being reported to the GMC for poor practice. You indicated that you sometimes found it difficult to prioritise patient administration because of your substantial clinical practice both for the HPSS and privately. You acknowledged that in many regards you needed to engage more proactively in face of	

		such requests as failure to do so often only compounded the situation, increasing the workload and putting at risk your relationship with patients and other parties. You also gave as a reason for delays in responding to a complaint a failure to be provided with adequate resources, specifically a broken computer and broken window in your office. Whilst these deficiencies need action by management I do not accept that they amount to a substantial explanation for the difficulties you have had in dealing with the issues highlighted at our meeting. Paradoxically you would have had an opportunity to raise such matters regarding resources if you had participated in annual job planning and appraisal, but I will nevertheless discuss these matters with your divisional management team. **Ongoing GMC Enquiry** You advised me during the meeting that you have been informed unofficially by the GMC that you are likely to receive a 5-year warning in respect of their ongoing investigation. This is very significant for a doctor, and I would ask you to act appropriately in future to ensure there is no further jeopardy brought on your fitness to practice. I would ask you to make yourself	

		familiar with the GMC Good Medical Practice document, which I have enclosed. **General** We also discussed your working practices, and you advised that since the introduction of the partial booking system, you had noticed a significant increase in the numbers attending your clinics. Indeed you indicated you were seeing up to 125 patients a week, with sometimes at least 40 being seen at one clinic for which you have little or no junior medical support. This is something you indicated you have raised as an issue in writing with your Divisional Director, Mr D Adams, and I will be pursuing this with Mr Adams. As our meeting concluded we discussed the status of your contract as you had chosen to remain on the old contract rather than transfer to the new contract. While this is your right, I do believe you should give this further consideration to ensure you are not suffering a detriment. Equally I should remind you that irrespective of what contract you are on, there is a requirement to participate in an annual job plan review and I will be asking your Divisional Management team to	

		provide me with an assurance that a job plan review is carried out urgently. It is via such a medium that many of the issues you accepted you had been struggling with are best raised and dealt with. I trust our meeting will prove productive in the long term. I will be asking your Divisional Management team for an update on each of these matters by the end of March 2007 so I trust progress will be made as was agreed at our meeting. Yours sincerely Tony	
2	4	4.103 What is noticeable about the conversation between Dr Stevens and Dr Watt is that there did not appear to be any reference to the policies of the Trust in respect of the obligations of an employee. A GMC sanction was referred to, but, apart from pointing out the existence of an obligation, there was no reference to disciplinary action or other internal sanction, which, in the view of the Inquiry Panel, would have been the appropriate tool of management when one was facing a straightforward breach of an employment contract. That said, the letter demonstrates that Dr Stevens wished to deal	4.99 What is noticeable about the conversation between Dr Stevens and Dr Watt is that there did not appear to be any reference to the policy of the Trust. A GMC sanction was referred to but apart from pointing out the existence of an obligation, there was no reference to disciplinary action or other internal sanction, which would have been the normal tool of management when one is facing a straightforward breach of an employment contract.

		with the situation that had arisen.	
2	4	4.103 Footnote 6: Dr Stevens did state in respect of a likely 5-year warning: "This is very significant for a doctor and I would ask you to act appropriately in future to ensure there is no further jeopardy brought on your fitness to practice".	No Footnote
2	4	4.106 Within days the complaint was closed.	4.102 Within days, the complaint was closed. The Inquiry has received no evidence or information concerning the holding, conduct or outcomes of any review of Dr Watt's clinics at this time.
2	4	4.110 …..the Divisional Director, Dr Adams and the Associate Medical Director, Mr Walby. While Mr Walby pointed out that this was the first doctor *"on his watch"* who had received a GMC sanction, there was a limited understanding of what a 5-year warning actually meant or what action if any should be taken by the Trust, nor did the Trust make any inquiry of the GMC as to what the warning entailed, or ask the GMC to seek to explain to the Trust the effect of the warning.	4.106 …..the Divisional Manager, Dr Adams and the Associate Medical Director, Mr Walby . While Mr Walby pointed out that this was the first doctor *"on his watch"* who had received a GMC sanction, there was no understanding of what a 5-year warning actually meant or what action if any should be taken by the Trust, nor did the Trust make any inquiry of the GMC as to what the warning actually meant, or the GMC seek to explain to the Trust what the warning meant.

2	4	4.111 On 20th March, Dr Stevens wrote to Dr Watt. He noted the warning, emphasised the importance…	4.107 On 20th March, Dr Stevens wrote to Dr Watt noting the warning, emphasising the importance…
2	4	4.112 On 29th March 2007, Mr Adams, wrote to Dr Stevens…	4.108 On 29th March 2007, the Divisional Director, Mr Adams, wrote to Dr Stevens…
2	4	4.112 An email of 29th March 2007…… …..Email correspondence suggests that the review was planned on 14th May 2007. In a written answer on 4th August 2020 to questions posed by the Inquiry, Mr Cooke stated that he did recall a job planning meeting at or about this time and believes it would have been on or about 14th May in his office. He told the Inquiry. A new and more detailed timetable was drawn up and discussed with Dr Watt … My recollection is that the purpose of the meeting was to agree a more specific timetable than was in place, within the limits of his contract ie to document his activities in an hour to hour format, rather than the previous timetable based on notional half days. It also included a detail on his on-call commitment. It was not a job	4.109 However, an email of 29th March 2007… …..Email correspondence suggests that the review was to take place on 14th May 2007. The Inquiry found no evidence that this job plan ever took place.

		plan review in the sense of how job plan reviews now take place under the 2004 Consultant Contract. I do not have a signed copy of this new timetable and assume this would have been placed in his file held in the directorate office. I have no other record of this meeting that I can find. I do not believe that I had any other job planning meetings with Dr Watt after that.	
2	4	4.113 A partially completed clinic template was forwarded to the Inquiry from Mr Cooke's computer, but there were no other documents available from Dr Watt's file in the Medical Director's Office.	New paragraph
2	4	4.116 …was inappropriate and may also give a helpful…	4.112 …was inappropriate and also gave a helpful…
2	4	4.117 Footnote 7: This is set out in the Complaints chapter.	New footnote
2	4	4.118 The Inquiry Panel noted that, as explained in more detail in the GMC chapter…	4.114 It is not without significance that, as explained in more detail in the GMC chapter,…
2	4	4.119 The Inquiry Panel recognises that the concept of managing doctors was only slowly evolving.	4115 The Inquiry Panel recognises that the concept of managing doctors was only

		Doctors and consultants, had been used to operating a different model where hospital administrators saw their role as one of supporting clinical practice. It is noted, from the evidence of Dr McBride that the American model of having both a full-time doctor and a full- time administrator in exclusively management roles was deemed to be too expensive for the NHS and, in Northern Ireland, the Department of Health. The Inquiry Panel accepts that medical managers had to undertake their managerial work within significant time constraints and with limited training and managerial experience. If however, the safety of patients is to be ensured then they must do so competently. The Inquiry Panel accepts that the culture of consultants, particularly historically, may have made their management more difficult. Because it was difficult did not mean that consultants should have been managed less effectively.	slowly evolving at this time. Doctors and consultants, in particular, had been used to operating a different model where hospital administrators saw their role as one of supporting clinical practice. It is noted, from the evidence of Dr McBride that the American model of having both a full-time doctor and a full- time administrator in dual managed roles was deemed to be too expensive for the NHS . The Inquiry Panel accepts that medical managers had to undertake their managerial work within significant time constraints and with limited training and managerial experience. If however, the safety of patients is to be ensured then they must do so competently. The Inquiry Panel accepts that the culture of consultants, particularly historically, may make their management more difficult. Because it's difficult does not mean that consultants should not be managed.
2	4	4.120 Footnote 8	4.116 Footnote 6

2	4	4.122 Further, the then Sub-Divisional Manager, Mr Watson was not aware of the warning, nor was the Patient Liaison Manager, Mrs Webb, nor were staff like Mr Atkinson or Ms Lundy, who…	4.118 Further, the then Sub-Divisional Manager, Peter Watson was not aware of the warning, nor was the Patient Liaison Manager, Mrs Webb, nor were staff like Gerry Atkinson or Clare Lundy, who…
2	4	4.123 Footnote 9: For the avoidance of doubt, the Inquiry accepts that the destruction of material was carried out pursuant to a document retention policy.	New footnote
2	4	4.126 As recognised by Dr McBride, with the benefit of hindsight, evidence of a…	4.122 As recognised by Dr McBride, evidence of a…
2	4	4.127 Addition of Footnote 10: From the Inquiry Terms of Reference.	New footnote
2	4	4.129 …was an early sign of a pattern emerging in diagnosis by Dr Watt which involved speed in reaching a diagnosis, inadequate testing and an alacrity in prescribing medication.	4.125 …was an early sign of a pattern emerging in diagnosis by Dr Watt involving speed of diagnosis, inadequate testing and an alacrity in prescribing.
2	4	4.130 This is despite the fact that neurologists and, Dr Morrow, the then Clinical Lead,…	4.126 This is despite the fact that neurologists and, in particular, Dr Morrow, the then Clinical Lead,…

2	4	4.132 The Inquiry Panel believe that the Coroner's inquest resulted in the Trust not investigating or addressing…..	4.128 The Inquiry Panel believe that the Coroner's inquest resulted in the Trust choosing not to investigate and address..
2	4	4.133 …regarding the diagnosis of epilepsy being forgotten…	4.129 …..regarding the diagnosis of epilepsy being quietly forgotten….
2	4	4.135 His final response is lacking and incomplete, in….	4.131 His final response is lacking and incomplete, even for 2007, in…
2	4	4.138 The Inquiry Panel accepts that Dr Stevens made repeated efforts to address a range of concerns regarding the practice of Dr Watt in 2006/2007. The consistent pattern was that complaints were made, Dr Watt was spoken to and often written to by the Medical Director or Assistant Medical Director, direction was given for compliance and then largely ignored. This pattern was presumably behind Dr Morrow's whimsical but inadequate response in 2009: As for Michael, you know the score, he has only ever been appraised once and despite regular reminders does not cooperate.	4.134 The Inquiry Panel accepts that Dr Stevens made repeated efforts to address a range of concerns regarding the practice of Dr Watt in 2006/2007. Despite this, the job plan review, which was to have taken place with Mr Cooke on 14th May 2007, would not appear to have been carried out. Such failure follows a consistent pattern. Complaints were made, Dr Watt was spoken to and often written to by the Medical Director or Assistant Medical Director, direction was given for compliance and then largely ignored. This pattern was presumably behind Dr Morrow's whimsical but inadequate response in 2009:

			As for Michael, you know the score, he has only ever been appraised once and despite regular reminders des not cooperate.
2	4	4.141 ….the problems in triangulating information ensured that,…..	4.137 ….the problems in triangulating information ensured that, in particular,..
2	4	4.143 Other difficulties emerged because incomplete… …of which he was aware, were omitted. This may have been because collating the complaints was not straightforward or that he simply focused on the ones, which he had more carefully considered. The Inquiry was unable to establish the status of INI 404, INI 408 and several complaints, which have now been destroyed. There is no evidence, however, that Mr Walby was aware of these complaints. The Inquiry was unable to ascertain what communication took place between Mr Walby and the Complaints Department so as to establish exactly how or why these complaints were not brought to the attention of the GMC. It appears to be the case that systems were not in	4.139 Other difficulties emerged because partial and incomplete…. …of which he was aware were omitted, as were INI 404, INI 408 and several complaints which have now been destroyed . This may have been because collating the complaints was not straightforward or that he simply focused on the ones which he had more carefully considered. The fact is that systems were not in place, which made the collation of relevant information a straightforward exercise.

		place, which could have made the collation of relevant information a straightforward exercise.	
2	4	4.144 …triangulated at this time, and, the clinical complaints…	4.140 …triangulated at this time and, in particular, the clinical complaints…
2	4	4.147 …administrative and resulted in several incidents…	4.143 …administrative and resulted in several key incidents…
2	4	4.149 None of this seems to have been intrinsic to addressing conflicts of opinion in 2006.	4.145 None of this seems to have been part of the way in which such medical conflicts were dealt with in 2006.
2	4	4.151 Dr Watt himself was concerned about the system for booking patients into his clinics. The Trust had an obligation to both the patients and Dr Watt to address these issues. Although there was one job planning meeting in May 2007 between Dr Watt and Mr Cooke, and the Inquiry Panel is aware of a temporary reduction in the number of patients being seen by Dr Watt, the situation soon reverted (with Dr Watt's encouragement) to where it had been previously. Many witnesses gave oral evidence and numerous written complaints viewed by the Inquiry highlighted, that Dr Watt's clinics continued to be handling patient numbers well	4.147 Dr Watt himself was concerned about the system for booking patients into his clinics. The Trust had an obligation to both the patients and Dr Watt to address these issues. This did not happen despite the Trust saying that it was being addressed in 2007 and many witnesses gave oral evidence that Dr Watt's clinics continued to be chaotic in the years that followed.

		in excess of the agreed template in the ensuing years. This issue is discussed further in the Complaints chapter.	
2	4	4.152 Although complaints about delay at his review clinic were common place and the Inquiry had received, at a highly relevant period, in January 2007, evidence of Dr Watt's clinic template being reviewed, there is little sense that the matter had been adequately addressed.	4.148 Although complaints about delay at his review clinic were commonplace and the Inquiry has at a highly relevant period, in January 2007, evidence of Dr Watt's clinic template about to be reviewed, there is little or no evidence of any such management action occurring . More importantly, the job plan review meeting, where such issues could be discussed with the Clinical Director would not appear to have taken place, despite Dr Stevens' direction.
2	4	4.163 The fact that the Board was unaware of specific problems did not absolve the Board of responsibility. It was the Board who had to ensure that there were systems in place, and adhered to, which allowed for effective management at all levels.	4.159 The fact that the Board is unaware of specific problems does not absolve the Board of responsibility. It is it who must ensure that there are systems in place and adhered to, which allow for effective management at all levels.
2	4	4.166 The problem was recognised retrospectively.	4.162 The problem was recognised.

2	4	4.167 The evidence suggests: (i) Management failed to follow its own policy with regard to appraisal; (ii)The Trust failed to ensure Dr Watt regularly carried out job planning which was a part of his contractual obligation; (iii) The Trust failed to address the overbooking of Dr Watt's clinics in a long-term manner; (iv) The Trust failed…..	4.163 The evidence points to consistently weak management at the various levels of management: (i) Management failed to follow its own policy with regard to appraisal; (ii) The Trust failed to ensure Dr Watt carried out job planning which was a part of his contractual obligation; (iii) The Trust failed to address Dr Watt's own concerns about the patients booked into his clinics (with both Dr Watt and his patients losing out); (iv) It failed…..
2	6	6.5 Footnote 1 Dr Lowry sadly passed away in April 2022 prior to the publication of this report.	New footnote
5	App C	Appendix C Royal College of Physicians Report 26th April 2018	Appendix C Royal College of Physicians Report 4-5 February 2021