BRIEFING TO THE HEALTH COMMITTEE

INDEPENDENT NEUROLOGY INQUIRY

21 OCTOBER 2021

In view of recent events and the decision of the Medical Practitioners Tribunal Service, ("MPTS") I believe that it is both appropriate and necessary to explain in greater detail a number of matters, in so far as I am able to do so, given my broader obligations as the Chairman of a statutory Public Inquiry.

I want to first of all express my disappointment at the decision of the MPTS. This disappointment is shared by Professor Mascie-Taylor. My understanding of the legal position is that it would have been open for the Tribunal to have proceeded in any event, even if Dr Watt was not in attendance. The GMC have indicated that there was no appeal against the decision of the MPTS to accede to Dr Watt's application for voluntary erasure. That may well be correct, but, nevertheless, I do note that the possibility of a judicial review of the situation could be investigated. The Inquiry Solicitor has been informed by the Chief Executive of the GMC that this is currently being considered and advice is being taken from leading counsel. If the MPTS had recognised that it was in the public interest to receive the evidence and make findings, even in the absence of Dr Watt, then I believe that this would, in part, have given the GMC the opportunity to properly adduce the evidence of many patients.

The present situation is unsatisfactory, particularly for patients and in this regard I am acutely conscious that patients have been told *"again and again"* that the GMC will be dealing with the regulatory aspects of Dr Watt's practice. I note and welcome the *"extreme disappointment*" of the GMC in their public statement. What concerns me most however is the lack of an explanation from the MPTS on why the public interest test was not satisfied in Dr Watt's case.

I fear the vacuum created leads to the Independent Neurology Inquiry being shouldered with expectations that cannot be fulfilled, because of the process we are required to follow within the Terms of Reference. While governance procedures and systems may be viewed as rather dry, the reality is that they are inextricably linked to good patient outcomes and an improvement in patient safety. I can state at this stage that our report will consider the relationship between governance and safe clinical practice.

I now want to address the issue, which I think has been at the heart of public concern; namely that in failing to have Dr Watt independently examined, I had conducted what amounted to a cursory examination of the issues. That is far from the case, as I seek to explain below. Although I am constrained in various ways in what I can legitimately disclose, I have approached this correspondence in the same manner that I adopted with the BBC in seeking to comprehensively answer their questions prior to broadcast.

Before setting out the legal considerations, I have outlined below the steps that were taken in a chronological format to assist understanding:

> On 15th of March 2021 the Inquiry issued a Notice compelling Dr Watt to attend and give oral evidence. On 6th May 2021 Dr Watt's lawyer disclosed expert psychiatric evidence to the Inquiry. On 18th May 2021 the Inquiry sent correspondence to Dr Watt's lawyer identifying a number of misapprehensions about the Inquiry's work and posing a series of questions about options for taking evidence. A further report from the same psychiatric expert was received on 22nd June 2021 addressing these matters and coming to the same conclusion.
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> On 1st June 2021 a series of incomplete text messages between Dr Watt and a patient, (known as 'Jane' in the BBC Spotlight program) were considered by the Inquiry Panel and its legal advisers. One message dated June 2019 was considered carefully, because one interpretation is the *emoji* implied that Dr Watt may have found find it amusing that he had been considered a suicide risk. The conclusion was reached that they did not have sufficient weight as to be relevant to either the Inquiry's Terms of Reference, in particular because the text message focused upon was dated 6-7 months before the first psychiatric examination by the expert psychiatrist retained by Dr Watt's lawyers.
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> On 25th June 2021 the Inquiry wrote to its own independent expert psychiatrist requesting a report in order to quality assure the expert psychiatrist report received from Dr Watt's lawyers. A report from the independent expert was received on 30th June 2021.
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> On 8th September 2021 the Inquiry took the additional precaution of providing copies of the messages to the independent expert psychiatric expert and the expert psychiatrist instructed by Dr Watt in order to judge whether the original consideration on the

relevance of texts was valid or whether either of the experts wished to reconsider their opinions.

On 12th September 2021 the expert psychiatrist instructed by Dr Watt provided an addendum report to the Inquiry re-affirming their view that Dr Watt was not fit to give evidence.

On 13th September 2021 the Inquiry's independent expert provided an addendum report to the Inquiry re-affirming their view that Dr Watt was not fit to give evidence. The independent expert psychiatrist commented in their addendum report that trying to draw conclusions about mental state and risk from text messages is *"inappropriate, risky and unhelpful."*

The factors considered in concluding that Dr Watt would not be able to give evidence included: -

(i) The fact that the Inquiry had received a detailed psychiatric report, where an examination had initially commenced in December 2019 and continued with further examination in September 2020, February 2021, and April 2021. The most recent examination was nearly 2 years after the text message in June 2019 wherein Dr Watt referenced his own mental health. The Inquiry was satisfied that it had in its possession a contemporaneous and substantive assessment carried out not just by the expert psychiatrist instructed by his lawyers, but with the report being informed by a separate treating psychiatrist as well as a psychologist attached to the community mental health team, both of whom had also examined Dr Watt.

(ii) Even allowing for this, the Inquiry had already raised a series of questions with the expert psychiatrist to explore every possible option. When those answers were subsequently received the Inquiry had more than sufficient evidence to come to a conclusion. Nevertheless I decided as an additional precaution to obtain a further report from an independent expert psychiatrist report.

(iii) The reports received from the psychiatrist retained by Dr Watt and the psychiatrist asked to report separately to the Inquiry all exhibit a declaration of truth and a statement indicating that any conflict of interest is disclosed (there were none).

(iv) I was required to apply the legal test[1] as to whether there was sufficient evidence to cast serious doubt on the medical opinions

already expressed. It might be helpful to explain that had I concluded that there was serious doubt the matter would ultimately have had to be determined by the High Court and the starting point is to consider whether there has been some fundamental flaw in the assessments carried out. The fact that a witness was or was not independently examined by the body issuing the witness summons is not necessary for a court to come to a conclusion. There must be some obvious and serious failing in the medical evidence, before a court would decide to look behind the assessment of a relevant medical practitioner.

(v) I also was cognisant of the fact that we had received a draft copy of the Verita report, which included a detailed transcript of evidence Dr Watt had provided in May 2019. Recognising that the Independent Neurology Inquiry was not the Dr Watt inquiry it was apparent that as much as Dr Watt's attendance at the Inquiry would have been beneficial, it did not at all prevent a report being completed within the Terms of Reference.

(vi) At each stage, I considered the matter with not just my co-panellist Professor Mascie-Taylor, but with the Inquiry Solicitor and the Senior Counsel appointed to the Inquiry. Meetings to consider these matters were comprehensive and detailed.

(vii) In good faith, the unanimous view of the Panel and its legal advisers was that there was nothing in the reports furnished, which brought into question the veracity of any of the conclusions.

The Inquiry can at any time before it reports give further consideration to the issue of Dr Watt's fitness to give evidence. Any such consideration, however, must be based on appropriate expert evidence and a material change in circumstances. The Inquiry remains ongoing, and will continue to assess and weigh up relevant material until the report is finalised.

As I have sought to explain the reality of how the decision was taken differs materially from the perception of how it was made. In particular, I would highlight the following matters which I fear have been misunderstood:-

(1) The initial reports I had received included input from a further treating psychiatrist and a psychologist who was part of a Community Mental

[1] See, for instance, the decision of David Richards J in ***Re: Coroin*** [2012] EWHC 2343

Health team, both of whom had agreed with the views of the psychiatrist who provided the report.

(2) There were four separate examinations over a period of 18 months by the psychiatrist who prepared the report.

(3) In understanding the decision it is critical to apply the requirements of the legal test. Was there any serious reason to doubt the conclusions of the evidence that had been obtained? The case law makes it clear that it is not at all usual for a court to look behind the clear conclusions of a medical report. The fact that the Inquiry decided, as an additional precaution to obtain an independent view on the manner in which the reports had been compiled, was, in truth, acting out of an abundance of caution. There was quite clearly sufficient evidence to make a decision based on the legal test on the evidence already obtained.

(4) Only the Inquiry can be in a position to assess the evidence, which is not in the public domain and cannot be disclosed

I replied at length to a number of patients representing the Independent Neurology Recall Support Group on 11th October and received a helpful and constructive response, which made clear that the Group were appreciative of the explanation provided.

Overall Progress of the Inquiry:

As previously indicated, the oral evidence was effectively completed in June 2021. The issue with regard to Dr Watt has been explained in detail above. I should make clear, however, that as a result of further enquiries, and also aspects of the Spotlight programme, we have followed up with a discrete number of additional witnesses, particularly in relation to medical records. In addition, we have received a significant amount of further documentation from the Trust, which has now been analysed. The Inquiry report is at a very advanced stage. We believe that we can begin what is referred to as the Maxwellisation process in early November 2021. This will, of necessity, take a little time, but I remain anxious to deliver the report as soon as that process is completed.

The voice of patients was heard at the beginning and continues to be heard. It has helped to shape the direction of the report and the issues, which need to

be focused upon. We remain determined to produce a meaningful report with clear recommendations based on the premise that patent safety is and remains the paramount consideration.

Brett Lockhart QC, Chairman
Professor Hugo Mascie-Taylor, Panel Member

Independent Neurology Inquiry

INDEPENDENT NEUROLOGY INQUIRY

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Northern Ireland Assembly
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Our ref: BL-0014-21

Date: 21 October 2021

By email to K McBride, Committee Clerk

Dear Colm

RE: Independent Neurology Inquiry

The Inquiry have been contacted by the Clerk to the Health Committee asking whether it would be possible for the Inquiry to attend at a closed session of the Committee on 4th November 2021 at the same time or immediately after the appearance of the GMC, the Department and the RQIA.

Can I initially indicate that as demonstrated throughout the period in which we were operating as a non-statutory Inquiry that we take the role of the Health Committee as critically important. To this end, we appeared before the Committee in October 2020 to update Members on progress and to answer queries that arose at that stage. Prior to the restoration of the Assembly in January 2020 we, at our own initiative, met regularly with the health spokespersons for each political party and gave them as detailed a briefing as possible on progress.

When the Inquiry Secretary suggested to the Clerk of the Health Committee that Professor Mascie-Taylor and I could meet with the Chairman and Vice Chairman prior to sending a full written briefing albeit any discussion would have been solely focussed on process, I did so out of respect for the role of the Committee. I do understand why that causes a problem for other Committee Members, who would not have had the opportunity to ask questions directly.

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In regretfully declining the revised invitation to appear before a closed session I want to assure Committee Members that no disrespect is intended. I have also enclosed with this correspondence detailed written briefing. It is my sincere hope that the contents of this briefing will adequately explain the relevant issues in a manner, which clarifies any public misunderstanding that has arisen.

My reasons for declining the invitation are as follows:

(i) There is nothing we can usefully add to the detailed written briefing without straying into sensitive issues, which will be properly discussed in the report or fall outside the Inquiry's Terms of Reference.

(ii) The Inquiry has reached the most sensitive part of its role in that the *'Maxwellisation'* process is due to commence at the end of this month. This will enable parties criticised in the report to comment before publication

(iii) I wrote to a patient group in October 2021 in response to a number of detailed questions setting out in similar detail the steps taken in relation to the attendance of Dr Watt and have been reassured by the various responses received that the explanations provided were helpful and reassuring.

(iv) As a statutory inquiry we are required to maintain our independence and work within a statutory framework. I have to be mindful of setting a precedent, which may be difficult for other inquiries. We did attend previously as a non-statutory inquiry because, I felt it was important to be as transparent as possible, given that the evidence received was not given in public.

If I was not so constrained I would be anxious and willing to directly answer the questions that have emerged. It is for this reason that I have taken significant time in the written briefing to explain our position as comprehensively as possible.

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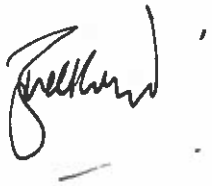
I trust that the enclosed will be received as a sign of our good faith and respect for the workings of the Committee.

Yours,



Brett Lockhart QC
Chairman
Independent Neurology Inquiry

Enc: Terms of Reference
Health Committee Briefing

Terms of Reference for the statutory Public Inquiry established to review matters related to the Neurology Service provided by the Belfast Trust

This Public Inquiry has been converted from the original non-statutory Independent Neurology Inquiry (INI). The Chairmanship and panel for the inquiry will remain unchanged from the INI.

The work will form part of a series of actions which have been initiated by the Department in response to the recall of patients. This includes work being taken forward by the Regulation and Quality Improvement Authority (RQIA) as follows:

- A review of the governance of outpatient services in the Belfast HSC Trust, with a particular focus on neurology services. This review will then be extended to cover all four remaining HSC Trusts over the subsequent 12-18 months;
- An expert review of the records of all patients or former patients of Dr Michael Watt, who have died over the past ten years; and
- A review of the corporate and clinical governance of health services delivered in the independent sector in Northern Ireland.

The clinical practice of Dr Michael Watt is being investigated by the General Medical Council (GMC) and employer led processes under Departmental Guidance on "Maintaining High Professional Standards in the Modern HPSS", it would, therefore, be inappropriate for the Public Inquiry to encroach on the GMC's remit or employer led processes. However, the Panel will consider the role of the Trust as an employer in terms of professional practice in the context of the Trust's system of Governance during the period covered by the Public Inquiry.

The Terms of Reference of the Public Inquiry remain unchanged and are outlined below:

a) In relation to the circumstances which led to the recall of patients in May 2018 (for the period from November 2016 until May 2018), to evaluate the corporate governance (with particular reference to clinical governance) procedures and arrangements within the Belfast Trust. 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;

b) To review the Belfast Trust's handling of relevant complaints or concerns, identified or received prior to November 2016, and participation in processes to maintain standards of professional practice, including appraisals. The Panel are asked to determine whether there were any related concerns or circumstances which should have alerted the Belfast Trust to instigate an earlier and more thorough investigation over and above the extant arrangements for raising concerns and the existing complaints procedure; and
c) To identify any learning points and make recommendations to the Department in relation to points (a) and (b) above. In particular to consider the application of any learning arising from the Inquiry to the framework for clinical social care governance, the current balance between problem sensing and assurance seeking in the extant system and its underpinning processes.

The Public Inquiry Review Panel will be chaired by Mr Brett Lockhart QC working together, and in partnership with Dr Hugo Mascie-Taylor.

The methodology to be used by the Public Inquiry Review Panel is outlined below:

There are 2 main phases envisaged of the Panel's work; to submit a preliminary report as soon as practicable to the Department and at that stage advise the Department as to when the final report and recommendations will be provided to the Department. Should the Panel, as part of their Review, establish any issue of concern, which they believe needs to be brought to the Department's immediate attention, then this will be done.

The Public Inquiry will be an inquisitorial inquiry. The Panel has a legitimate expectation of full cooperation by all parties involved, as affirmed by the Department, reflecting the professional duty of candour and HSC Code of Conduct. The Chair will determine how further they wish to conduct the review.