

29 November 2021

## **Reviews re Blood Patches, Intracranial Hypotension and Royal College of Physicians Report**

### Questions:

- 1. In March 2017 you advise that a colleague review found problems suggesting blood patches.**
  - a) What date did this review begin?**
  - b) Please provide a copy of that review.**
  
- 2. In April 2017, you advise that this 200 case file review was considered.**
  - a) Considered by who?**
  - b) Please provide a copy of all correspondence.**
  
- 3. In May 2017, you advise the blood patching audit was completed and restrictions were placed.**
  - a) Please provide a copy of this audit.**
  - b) What were the restrictions?**
  
- 4. In June 2017, an Intracranial Hypotension review was completed.**
  - a) Please provide a copy of that review.**
  
- 5. In April 2018, the Royal College of Physicians report was completed.**
  - a) When did this review begin?**
  - b) Please provide a copy of that report.**

### Response:

It is noted that the FOI applicant has indicated within the questions posed, statements attributable to Belfast Trust. It has not been possible for the Trust to identify these statements from our own records, although we are grateful to the applicant for indicating firstly that they came from information provided to Nichola Mallon, and secondly from Belfast Telegraph articles.

It may be helpful if we set out briefly the chronology in these matters.

As noted in the Press Statement of 18 May 2018 - "Concerns were initially raised in December 2016 by a GP (and later by a Trust Consultant) in relation to the care and treatment provided by Dr Watt to a small number of his patients. The Trust immediately took steps to restrict Dr Watt's practice in the areas of his practice where concerns were identified."

We can confirm that the areas of practice, which were the subject of restriction from December 2016, were in relation to new diagnoses of Spontaneous Intracranial Hypotension (SIH) and treatment plans in review patients who had previously been diagnosed with SIH.

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The restrictions in practice were as follows:-

1. When presented with any NEW case, which Dr Watt considered was indicative of a diagnosis of SIH, Dr Watt had to discuss the diagnosis and treatment plan with a named consultant colleague.
2. When presented with any REVIEW case, which he had previously considered was indicative of a diagnosis of SIH; Dr Watt had to discuss the treatment plan with a named consultant colleague.

During the early months of 2017, a colleague of Dr Watt at the Trust reviewed the case notes of those patients who were at that time on Dr Watt's waiting list for a blood patching procedure. That review indicated that the majority of the patients on that waiting list were not suitable for a blood patch procedure, in the opinion of Dr Watt's colleague.

At that time (April 2017), it was identified that approximately 200 to 250 patients had had blood patch procedures previously, and so it was envisaged at that time that the Royal College of Physicians would be asked to undertake an independent expert review of circa 200 case notes for those patients who had had a blood patch procedure.

Further to discussions with the Royal College of Physicians, it was agreed that it would be appropriate that a decision regarding what cases the Royal College of Physicians would review, would be made after the completion of the review of 6 cases of concern. These being the cases of concern identified by the GP and the Trust Consultant in late 2016, which was being undertaken.

The review of the 6 cases of concern concluded in late May 2017, and it was considered that further restrictions were required in addition to those for blood patching.

These new restrictions in practice were that any new diagnosis of MS or treatment changes from first line to second line therapies would have to firstly be discussed with a named Consultant Neurologist, with such discussions recorded in the patient notes.

Further concerns arose later in June 2017 and so it was ultimately decided that Dr Watt would be restricted from all clinical practice (i.e. he could not see patients) from July 2017.

It was then agreed that a range of case notes from across Dr Watt's practice should be reviewed by the Royal College of Physicians, and that review began in autumn 2017. A draft report was received from the Royal College of Physicians in March 2018 and then a final report was received in April 2018.

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The various reviews were in relation to the individual practice of Dr Watt and therefore are exempt from the Freedom of Information Act Section 40(2) containing as they do Personal Information Relating to a Third Party

The recall letters were delivered to patients on 1 May 2018.