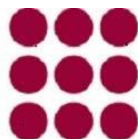

NINESTJOHNSTREET

EXECUTIVE SUMMARY
TO THE INVESTIGATION REPORT
PREPARED ON BEHALF OF
THE NORTHERN CARE ALLIANCE
NHS FOUNDATION TRUST

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Introduction

1. I have been instructed by Dr Owen Williams OBE, the Chief Executive of the Northern Care Alliance NHS Foundation Trust (the "**Trust**"), to undertake an independent investigation (the "**Review**") in accordance with a letter of instruction that was provided to me, together with a remit in March 2022. The remit has subsequently expanded to consider wider issues. By reason of the contextual factual background, I am required to examine events between 2006 and 2023 (the "**Relevant Period**").

2. My instruction is to make findings I consider relevant to the remit provided, together with issues that have arisen subsequently which I have been instructed to consider.

Background

3. There has been a significant organisational change within the NCA during the Relevant Period. The Trust was established as an NHS Foundation Trust on 1 October 2021 following a merger of (1) the Salford Royal NHS Foundation Trust and (2) the Pennine Acute Hospitals NHS Trust, which had been separate legal entities operating together as the Northern Care Alliance (the "**NCA**") under a single management structure since 1 April 2017. References to the Trust should be construed to encompass both the Trust and the NCA, as then constituted, unless otherwise specified.

4. The letter of instruction states that the Review was predicated on a meeting which took place in November 2021 between the Chief Executive of the Trust and Freedom to Speak Up Guardian. During this meeting, concerns were expressed by up to 16 employees of the Trust who referred to themselves as the "bullied staffing group" ("**BSG**"). The concerns related to a former spinal consultant at Salford Royal Hospital ("**Doctor F**").

5. The concerns were that:

5.1. There was a history of negligent and fraudulent clinical practice by Doctor F leading to present-day serious life-threatening harm to patients.

5.2. There was a history of poor clinical practice by Doctor F, including not treating patients in a dignified manner during physical examinations.

5.3. There were behaviours towards several Trust employees, including BSG colleagues, such that these employees regularly felt bullied, intimidated and harassed by Doctor F. This behaviour included unsolicited sexual contact with some female colleagues.

5.4. There was an extramarital affair between Doctor F and a senior divisional managing director of the Trust ("**Manager A**"), which allowed poor clinical practices and behaviours to continue to the detriment of the wellbeing of patients and employees.

5.5. During investigations into Doctor F's conduct and clinical practices, that Manager A abused their management position to influence the investigations in the hope of benefitting Doctor F.

5.6. Senior managers at Salford Royal Hospital colluded with Doctor F either through giving undue weight to their perspective, or through turning a 'blind eye' to the impact of their extramarital affair.

Remit of the Review

6. I was provided with the following initial remit:

6.1. To consider the chronology within the Relevant Period (as stated above).

6.2. To review the material supplied to the General Medical Council ("**GMC**") and make an assessment as to whether their subsequent findings may warrant a further referral to them.

6.3. As part of any GMC re-referral considerations, to consider the findings from the first phase of the Trust's Spinal Patient Safety Look Back

Review (“**SPSLBR**”)[1], which was ongoing at the time of my initial instruction but has since concluded. This includes the expert opinion of a consultant adult and paediatric orthopaedic surgeon (“**Independent Expert A**”) who was instructed by the Trust to consider five index cases, including that of Patient A (defined below).

6.4. To interview representatives of the BSG.

6.5. To produce a ‘lessons learnt’ report (this Executive Summary Report, together with the full “**Report**”) for use as a frame of reference by the Trust to consider whether the areas of concern relating to management, culture, custom and practice are prevalent in the Trust today.

7. This Review has taken a considerable amount of time, and the remit has expanded as I have progressed. Where issues arose which did not form part of the original remit, I have sought instructions from the Chief Executive of the Trust to consider those matters. For example, I have also been instructed to consider the following matters:

7.1. A review concluded in January 2016 by the Royal College of Surgeons (“**RCS**”) of a selection of Doctor F’s patients (the “**RCS Review**”).

7.2. The questions raised by a journalist (“**National Journalist A**”) who was, at the time, employed by the Health Service Journal (the “**National Journalist A Questions**”).[2]

7.3. The actions or inactions of the Trust in its response to the findings of the RCS Review and the National Journalist A Questions, including the Trust’s assertion that it had no ongoing concerns in relation to patients treated by Doctor F. I was assisted in this consideration by

[1] https://www.northerncarealliance.nhs.uk/news/nca-news/northern-care-alliance-releases-findings-its-spinal-patient-safety-look-back-review

[2] Note that, in order to assess whether the Trust’s responses to the National Journalist A Questions were accurate, it was necessary also to review the Trust’s response to concerns relating to Doctor F in 2015.

the expert opinion of Independent Expert A, whom I instructed in relation to the RCS Review and the National Journalist A Questions.

8. The Report was further delayed as I was not made aware of an investigation into the haematology aspect of the death of a patient ("**Patient A**") under the care of Doctor F at Salford Royal Hospital, who sadly died in the operating theatre on 27 February 2007, until late in the process. This information was uncovered by the Trust's solicitors when examining email communications. In addition, I was not aware of the involvement of National Journalist A and the existence of the National Journalist A's Questions for a considerable period of time.

9. One of the principal focuses of this Report is to examine what led to the death of Patient A, and what action the Trust took or did not take following their death. As such, I have examined in great detail the circumstances surrounding their death and the subsequent actions taken by the Trust.

10. Partly as a result of the long timespan of the Relevant Period, and partly due to the way in which evidence has been presented to me, I have had to try to piece together multiple accounts of what happened. I have had to interview a number of individuals multiple times to confirm or deny factual issues as they have arisen. Furthermore, this Report has been subject to a "Maxwellisation" process, which means that where extracts of my draft full report are critical of an individual, those extracts are sent to the individual for comment and for the opportunity to provide further information to me prior to the Report's finalisation. Given the number of individuals involved in this process, this has taken an extraordinarily long time.

11. The notes of all interviews, including those with management and members of the BSG, are contained within my full report, but they are not intended to be a verbatim account. All the evidence provided from those involved in this Review has been considered, but if I have not relied on it in making my conclusions, some evidence may not have been expressly referenced in this Report. Certain allegations have, at my discretion, been redacted or omitted, and I have attached less weight or no weight to certain unverified allegations.

The BSG

12. Although the remit was originally to interview representatives of the BSG, the Chief Executive instructed me to extend the remit to invite all members of the BSG for interview, following a request by the Freedom to Speak Up Guardian.

13. I understand that the BSG was devised as a forum in which senior clinicians and staff of the Trust could express their views in a safe and non-judgemental environment in relation to any aspect of their working lives.

14. The general theme recounted to me was a culture within the spinal division of the Trust of bullying, intimidation and aggressive behaviour by Doctor F. There was a distrust of senior management, whom it was felt were protecting Doctor F and/or Manager A.

15. My notes of interviews with some members of the BSG make for very concerning reading. I was very troubled to hear allegations of racism: that most Black, Asian and Minority Ethnic ("**BAME**") staff felt and still do feel that they were and are treated as second-class citizens.

Key questions

16. The Review covers not only events leading up to the death of Patient A, but also the events after their death. It considers the actions or inactions of the Trust and individuals within it. The Review also inquired into the other four index cases (as referred to Independent Expert A) as relates to Doctor F, up until the publication of the SPSLBR in 2023.

17. This Report considers the 'lessons learned'. In order for lessons to be learned, it is necessary for me to make factual findings, where findings can be made on the evidence presented.

18. The allegations are serious. To determine the full extent of the concerns raised, it was necessary to consider the following key questions:

18.1. What did the Trust and its personnel know about Doctor F's clinical practice, up to the point of their dismissal in January 2015? Had serious concerns about Doctor F been raised?

18.2. Did the Trust carry out a full and detailed investigation into any clinical concerns regarding Doctor F's practice? If so, when? If the Trust did not carry out a full and detailed investigation, what were the deficiencies?

18.3. Did the Trust comply with its own policies and procedures in relation to staff concerns and allegations?

18.4. What was the culture of the Trust at the time that Doctor F was employed? What culture exists today, particularly within the spinal surgery division?

18.5. Did the BSG have legitimate concerns regarding Doctor F? If so, were these matters properly referred to the GMC?[3]

18.6. Was there any evidence, at the time, that Doctor F was having an affair with Manager A? Was there any evidence that they, together or individually, were responsible for a culture which was detrimental to the Trust and/or that they, together or individually, were able to influence matters under investigation to benefit Doctor F?[4]

18.7. In relation to Patient A, what was the chain of events before and after their death? In relation to Patient A and the other four index cases, did the Trust discharge its duties and investigate concerns? This includes an examination of the roles of various individuals and the evidence during the Relevant Period, culminating in the 2023 publication of the SPSLBR which examined more than 100 patients who had been under the care of Doctor F.

[3] To be clear, I have not been asked as part of my remit to make findings of fact as to whether bullying or intimidation actually occurred, and I make no such findings in this Report.

[4] To be clear, I have not been asked as part of my remit to make findings of fact as to whether Doctor F or Manager A have manipulated governance processes, and I make no such findings in this Report.

Chronology

19. Before turning to my conclusions, it is helpful to set out a brief chronology of the Relevant Period to assist in our understanding of the various reviews, investigations, reports and events:

    19.1. Patient A died in 2007. This Report considers the relevant events leading up to their death, from 2006, and following their death in 2007.

    19.2. Following Patient A's death in 2007 there was a limited investigative response which did not identify or investigate a causal connection between the death of Patient A and the fact that two surgeons did not operate.

    19.3. Doctor F was subject to a disciplinary investigation by the Trust in 2014 (the "**Disciplinary Investigation**").

    19.4. Doctor F was dismissed by the Trust in January 2015.

    19.5. During 2015, an internal review of Doctor F's patients took place (the "**2015 Review**").

    19.6. In August 2015, an alert of a serious incident requiring investigation (referred to as a "**DATIX**") was lodged by a Trust employee following information passed to them by a colleague in relation to the death of Patient A. This alert identified that there was a causal connection between the death of Patient A, and the fact that two surgeons did not operate on them.

    19.7. A further internal review undertaken by a surgeon and management concluded in May 2016 (the "**May 2016 Review**").

    19.8. The RCS Review of a selection of Doctor F's patients concluded in early 2016. The Trust's management wrote a letter to the former CEO ("**Leader A**") containing assurances from spinal surgeons of a low or non-existent risk of patient harm (the "**June 2016 Letter**").

19.9. The National Journalist A Questions were raised of management in September 2016.

19.10. The investigative response continued in 2015, culminating in a report by "**Doctor H**" in November 2021 (the "**Doctor H Report**").

19.11. In 2022, the Retrospective Serious Untoward Incident Report ("**RSUI Report**") is prepared and published by the Trust following the Doctor H Report. The RSUI Report relied on the expert opinions of two doctors ("**Independent Expert B**") and ("**Independent Expert A**") in relation to the death of Patient A.

19.12. The SPSLBR reviewed over 100 of Doctor F's former patients and was published in 2023.

A note on the Trust's governance and culture

20. To understand the background of the Review, I have considered allegations of governance manipulation, intimidation and bullying that were reported to me within the spinal surgery division of the Trust during the Relevant Period. Based on the accounts of multiple individuals, there was clearly a very difficult working environment during the time Doctor F was an employee.

21. In the context of the culture present within the spinal surgery division, I have considered the RCS Review, which notes the "*good working relationships between all of the consultant spinal surgeons who see their colleagues as helpful and supportive*" and also states that many consultant spinal surgeons reported an atmosphere and morale that had much improved following Doctor F's dismissal. Training grade surgeons also reported that the division was "*a good place to work*." I have considered these observations carefully, alongside a letter written by the chair of the RCS Review team in January 2016, which pointed to significant concerns of bullying and unfair treatment. I have also considered my own interviews, where multiple individuals have recounted a poor culture and working environment both before and after Doctor F's dismissal.

22. The Trust requested the RCS Review of its governance, and management and surgeons collaborated to produce a 65 point action plan. The Trust also put in place various measures to address concerns, including:

    22.1. developing its people strategy with specific action on issues of bullying and harassment;

    22.2. introducing an externally-operated hotline for staff, students and contractors to raise matters with Trust management;

    22.3. being an early adopter in the NHS of the 'Freedom to Speak Up' Guardian system in 2015/16; and

    22.4. continuing to improve the culture within operating theatres, as acknowledged by the Care Quality Commission ("**CQC**") in 2015 and 2018.

23. I have also considered the response of the Trust internally and, in particular, the fact that the Trust took immediate action by initiating an investigation, and suspended Doctor F from duty on the 10 September 2014 following the receipt of the anonymous letter of the 5 September 2014. I have considered and taken into account the fact that Doctor F was dismissed by the Trust in response to one particular allegation. I have considered the referral that was made to the GMC together with the relevant evidence, and their conclusions.

24. I have very carefully considered the evidence given to me by management which encompasses the chronology from 2006 to 2023. I have considered documents that have been helpfully made available to me relating to the culture of the organisation, and documents which clearly demonstrate the exceptionally good work that has been undertaken to better improve the Trust. I have balanced all the evidence that I have been provided with, together with the multiple accounts that I have been provided relating to the time frame in question.

25. Inevitably as a result of my investigation, I have made criticisms of certain individuals, entities, and the Trust. I reasonably believe that such criticisms

are fairly made and based on the evidence or facts presented to me. As I have stated above, my remit does not require me to make findings of intimidation, bullying or governance manipulation, and I make no such findings. I have nonetheless considered these allegations as part of the overall information available in relation to the culture of the organisation within spinal surgery, at the time that Doctor F was employed by it, and following their dismissal.

Key findings and conclusions

My full report is very lengthy and detailed. Therefore, I set out below a summary of my key findings and conclusions:

26. **Patient A**

26.1. I accept the expert evidence of Independent Expert A and the conclusions of the Doctor H Report. I accept and rely upon the expert evidence of Independent Expert A in concluding that Patient A’s death was caused by the failure of Doctor F to organise a second consultant for surgery, which compounded the risks and led to higher than usual blood loss.

26.2. In the absence of evidence to the contrary, I accept Independent Expert A’s further conclusion that Doctor F misled the coroner as to the severity of the quantity of blood lost in Patient A’s surgery.

26.3. I accept the findings and observations of Independent Expert B that there was an underestimation of bleeding by the surgeon and the anaesthetist, and that there was a missed opportunity to abandon surgery earlier which may have enabled control of bleeding and successful resuscitation. They go on to state that “*no learning has been identified from the incidents, and that there was a failure of Trust governance process and by the Trust of its duty of care to the Patient A family*”. It is also the opinion of Independent Expert B that there was “*a lack of anaesthesia pre-operation planning*”. I adopt these findings and observations in the absence of any evidence to the contrary.

The "two-surgeon" decision in relation to Patient A's surgery

26.4. I have examined in extensive detail the planning for Patient A's operation. On balance, I conclude from the available evidence that a decision to have two surgeons present for Patient A's operation was made in 2006. I again conclude from the evidence that a multidisciplinary team meeting took place in 2007, before the operation of Patient A, where it was agreed that a second consultant surgeon was necessary for Patient A's operation because of its complexity. Independent Expert A states that "*the lack of a second consultant surgeon expressly against the advice of the MDT is **unacceptable and extremely difficult to justify**. That, plus the decision to proceed with an orthopaedic registrar, I believe directly contributed to the patient's death due to the inevitably slower surgery. **This decision in my opinion exhibits blatant disregard for the patient's safety** in such a complex case involving a physically vulnerable young person. The **sad adverse outcome is predominantly due to poor decision making around fundamental aspects of safe practice.** It is my opinion that this would in the presence of all the details be the opinion of a reasonably competent expert in this field*" (emphasis added). In the absence of any expert evidence to the contrary, I accept and adopt this conclusion.

The investigation following Patient A's death

26.5. I have considered all the evidence available to me in the period before and after the death of Patient A. Whilst it is clear that, in the aftermath of their death, the Trust carried out an investigation, that investigation was limited to haematology, and not the surgery itself. Independent Expert A's opinion is that there was little or no investigation into the planning steps prior to the operation. If a Serious Untoward Incident was registered at the time, there are no documents relating to it. Rather, a Serious Untoward Incident has been constructed into a report recently and retrospectively. In my view, the Trust should have carried out a detailed analysis into the cause of death from a surgical

perspective and not limited itself to an investigation relating to haematology.

26.6. In my view, and based on the evidence of Independent Expert A, the death of Patient A was dismissed as an expected complication of surgery. Had the Trust carried out a detailed investigation into the surgical aspect of the death of Patient A, akin to the analysis of Independent Expert A or indeed Doctor H, I believe that the Trust would have established the deficiency in the process, in that best practice should have dictated the two surgeons should have conducted the surgery.

26.7. I agree with Independent Expert A's opinion that the Trust failed to review the actions of Doctor F and that there was a failure of governance. Independent Expert A describes the events as a "*surgical catastrophe*." In the absence of any evidence to the contrary, I adopt this opinion.

27. **The RSUI Report**

27.1. I adopt the following conclusions of the RSUI Report, in which serious concerns are identified in relation to patient harm regarding the five index cases, including Patient A:

(a) Expected governance processes were not followed in Patient A's case.

(b) There is no evidence identified as to why a causal connection between the failure to proceed with two surgeons and the death of Patient A was not explored.

(c) There was no investigation on causal contribution to the death of Patient A and the fact that two surgeons did not operate.

(d) There was a missed opportunity to review Patient A's care from a surgical and wider MDT perspective, in a timely manner to identify any potential issues in 2007.

(e) There was no consideration of the surgical management, and consequently no surgical issues were highlighted in 2007.

(f) In 2014 the link between the lack of a second consultant spinal surgeon and the death of Patient A was not identified following a concern being raised during the disciplinary investigation into Doctor F. This was a missed opportunity for the issue to be explored further.

27.2. The RSUI Report finds that an investigation took place in 2017/18. However, the RSUI Report states that this investigation was not completed, and the findings were not relayed to Patient A's family who, consequently, remained in the dark. In this 2017/18 investigation, the lack of a second consultant spinal surgeon is not recognised and is detailed as an "*incidental finding*". This investigation is described in the report as a missed opportunity to make further in-depth enquiries. I have found it difficult to rationalise how, based on the evidence of Independent Expert A and the Doctor H Report, the lack of a second surgeon can properly be described on the evidence as an "*incidental finding*".

28. **The DATIX**

28.1. The DATIX, lodged in August 2015, was the first occasion that it was officially reported to the Trust that a surgical error had caused Patient A's death. The issue had previously been raised in 2014 during the course of Doctor F's disciplinary investigation but had not been investigated by the Trust. I have explored this issue in detail. The DATIX made it clear that there was a link between the death of Patient A and the fact that two surgeons did not operate on them. At the point that the DATIX was filed, Doctor F had already been dismissed.

28.2. The RSUI Report records the following findings in the context of the DATIX, on which I rely:

(a) No further documentation has been located with respect to any governance processes which took place in 2015.

(b) The Trust, despite having knowledge of this serious issue, did not put in place an immediate and detailed investigation into the death of Patient A and if two surgeons should have operated, and whether this was causative of the death of Patient A.

(c) Accepted governance processes were not followed.

(d) The link between the absence of a second consultant spinal surgeon and the patient's death was not identified at this point.

(e) No evidence has been obtained which explains why there was no investigation into whether this issue causally contributed to the patient's death.

(f) There was a further missed opportunity for a further analysis of the patient's care.

29. **The 2015 Review and consequent findings**

29.1. As Independent Expert A states, and I accept, in preparation for the RCS Review, the 2015 Review sought to identify Doctor F's patients of concern that should be investigated by RCS. Patient A was not identified as a patient of concern.

29.2. Within my report, I have explored the reasons for the RSUI Report findings, which I summarise below. I have also sought Independent Expert A's expert opinion, the conclusions of which, in the absence of any evidence to the contrary, I accept.

(a) Patient A was listed as a patient of concern in August 2015 and in September 2015 but was no longer listed as a patient of concern in November 2015. Independent Expert A states that the governance system was not effective in the period from 2007 to 2015. The findings of the RSUI Report state that concerns with

respect to the patient's care and lack of a second consultant spinal surgeon, were raised by this point.

(b) It is stated within the RSUI Report that both governance and spinal colleagues were involved in the selection of the patients for the review but (for reasons that are unclear) Patient A was not selected. It is stated that it was a failing that Patient A was not included in the review and that this also led to a missed opportunity for an external review to have been carried out into the patient's care in 2015. The selection of patients is considered in more detail below.

29.3. It is not accepted by those spinal surgeons who were involved in this process that I have spoken to that they assisted in the selection of any patients for the review. Management believed that assurances were given in relation to which patients should be reviewed. I have explored this issue in detail in the full Report.

29.4. Independent Expert A's opinion is that the process of the review was inadequate. Independent Expert A refers to the process as being "*fractured*". They are of the opinion that the scope of the review was not adequately defined, and that the requests to clinicians were not explicit or detailed. Independent Expert A states that this was a missed opportunity to define and deliver a comprehensive review. In my view, from the evidence I have considered, there was a breakdown in communication, and Independent Expert A, I believe, comes to a similar conclusion. I accept that management believed that they had been provided with assurances and did accept the assurances. Independent Expert A also states that management acted reasonably in responding to assurances they felt they had been given and acted in good faith in offering their assurances to others.

29.5. In my view, it is reasonable to conclude from Independent Expert A's opinions that there was a governance failure, which is supported by the findings of the RSUI Review. The subsequent RCS Review did not

identify concerns with those patients that it reviewed. This provided a false reassurance to the Trust.

29.6. The RCS Review has therefore been materially undermined by the evidence of Independent Expert A. In my view, the reason why the Trust did not commission a full investigation into the DATIX is because the reviews carried out in 2015 did not identify Patient A as a patient of concern, when clearly, they were (as concluded from the evidence of Independent Expert A).

29.7. From the various accounts provided to me, I believe it reasonable to conclude that spinal surgeons were asked to consider various patient lists. Evidently some patient lists were considered, and ad-hoc, informal observations were made on those lists or on certain patients contained within them. The evidence from the spinal surgeons I consulted was that they were not asked to prepare an in-depth analysis of patients to be put forward for the review, and that there was no involvement in patient selection. As stated, management believed that there had been a selection of patients for review by spinal surgeons and this belief was genuinely held. Similarly, I believe that the spinal surgeons I consulted genuinely believed that they were not asked to undertake an in-depth review of patients to be put forward for review. In my view, there was a breakdown in communication that led to Patient A not being included within the RCS review:

(a) They were not identified as a patient of concern to management.

(b) From a spinal surgeon viewpoint, this was because a detailed patient review was not requested by management.

29.8. In my view, had Patient A been identified they would have been selected for review. I believe it’s important to make clear that the accounts provided to me by management and by those surgeons that I have consulted were genuine accounts.

29.9. Whilst the accounts differed, each person attempted to assist me thoroughly. Each person provided me with an honest account of their recollections. It is not for me to determine, and indeed I do not determine, who is right and who is wrong. There was, in my opinion, a failure of the Trust's governance system, which I do not attribute to any one individual. I rely upon the evidence of Independent Expert A, the Doctor H Report, and the SPSLBR.

29.10. From various documents that I have seen, including Adverse Incident Report data (which is the way that NHS staff can raise concerns about patient safety), DATIX, copy emails, and so on, it shows that to some extent, concerns and/or complaints do not appear to be followed up, certainly whilst Doctor F was in post. This absence of follow-up is consistent with the comments made by individuals within the BSG and supports the perception of Doctor F's negative influence over prescribed procedure. The Trust did not undertake an investigation into any governance manipulation by Manager A or Doctor F, even though this allegation was first made in 2014.

30. **The May 2016 Review**

30.1. A further review took place in 2016, and I have examined this review extensively. The RCS Review, which reported in early 2016, did not identify patient harm. The 2015 Review of Doctor F's patients of concern (as I have set out above) did not identify Patient A as a patient of concern. These factors led to a misguided opinion that there was no ongoing harm, as is clear from the recent report of Independent Expert A.

30.2. The purpose of the May 2016 Review was not to establish whether there was ongoing harm, as I understand it. At the end of the 2015 Review, management held a firm belief that there was no ongoing harm. As stated by Independent Expert A, ongoing harm is a difficult concept in complex spinal surgery and therefore it is, sadly, understandable that as of September 2016, after a lengthy period of

investigation, the Trust's management felt it acceptable to declare no ongoing harm to patients and hence closed the review.

30.3. As set out within the RSUI Report, there is no evidence to indicate that the implication of the lack of a second consultant spinal surgeon on Patient A's death was recognised at this time. It is stated that the external review of 2022 was the first point at which it was specifically identified that the lack of a second consultant spinal surgeon directly contributed to the death of Patient A. It is stated that this May 2016 Review, should have prompted further exploration as to whether there was a causal connection between the issues raised, specifically, the lack of a second consultant spinal surgeon, and the patient's death. It is stated that this was a further missed opportunity to investigate this issue fully.

30.4. The SPSLBR concluded that a significant number of patients, including Patient A, are classed as having experienced harm. Taken with the evidence of Independent Expert A, it is clear that there was ongoing harm to a number of patients as of September 2016. However, as I have stated above, the May 2016 Review was not designed to establish whether there was ongoing harm to patients, as the Trust's management believed this question had been settled by the RCS Review, and the various assurances received. Instead, the May 2016 Review was to answer questions prompted by National Journalist A, and to determine the accuracy of the Trust's conclusions in relation to certain patients. In my opinion, there was a breakdown in communication between management and the spinal surgeons undertaking the May 2016 Review.

30.5. Patient A was identified in the course of this review as a patient of concern, with 9 review points. The spinal surgeon identified that two surgeons were required for the procedure, but that Doctor F proceeded alone. It is identified by the RSUI Report that there is no evidence to indicate that the significance of the lack of a second

consultant spinal surgeon on the Patient A's death was recognised as of 2016.

30.6. The June 2016 Letter set out the multiple assurances and reassurances that were given by spinal surgeons. Reading this alone, it would leave no doubt that complete assurances were received. However, the spinal surgeons I have consulted on this issue dispute that any assurances of this nature were provided. The surgeons also dispute that they were involved in regular wider management meetings to discuss any harm caused to Doctor F's patients. It is not for me to determine what was or was not said. In my view, management and spinal surgeons both did their best to assist me with their honest accounts of their genuine beliefs. However, in my view, the causal connection between the lack of a second consultant spinal surgeon and the death of Patient A was not properly considered, though it was identified. This was, in my view, due to a breakdown of communication which resulted in a further reassurance that there was no ongoing patient harm; therefore, no further action was taken at the time.

30.7. I adopt the conclusions of the RSUI Review and the evidence of Independent Expert A that the May 2016 Review was a missed opportunity. I do not attribute blame, but I rely on the opinion of Independent Expert A that the overall review process was inadequate and led to an underestimation of the degree of harm already experienced, and the potential for ongoing harm. This harm continued between 2015 and 2017, as identified by the SPSLBR and supported by the evidence of Independent Expert A.

30.8. It is clear to me that there was no detailed investigation by the Trust akin to the Doctor H Report or the detailed investigation by Independent Expert A from 2015-2021 into the death of Patient A. The point has been made to me that the connection between the death of Patient A and the lack of a second surgeon was not evident to the Trust until this was deciphered by Independent Expert A. However, in

my view, this failing is because the Trust did not investigate the death of Patient A from a surgical perspective before Independent Expert A's investigation, despite the fact they had the resources and material to do so, and despite the fact that concerns about the death of Patient A were raised during the course of Doctor F's disciplinary investigation in 2014. Had the Trust commissioned a detailed investigation of this kind, it is reasonable to assume they would have made this crucial connection. In Independent Expert A's opinion, it is reasonable to assume that further harm to patients could have been avoided had the Trust acted in 2010.

31. **Other patients of Doctor F**

31.1. Independent Expert A criticises the care Doctor F provided to **Patient B**. Independent Expert A states that the failure to proceed with the next phase of the operation for 90 minutes, with no communication with senior colleagues, was unacceptable and could potentially have led to a significant complication with a poor outcome as a result. They refer to the fact that the operation note bears no resemblance to the events as documented elsewhere and states that this is unacceptable and raises a serious probity issue. In addition, Independent Expert A states that the failure to review the patient at any stage and the failure to inform the patient of the events, is unacceptable and unprofessional.

31.2. In relation to **Patient C**, Independent Expert A states that the preoperative documentation and consent process refers to various concerns in relation to the multidisciplinary team meeting. They are concerned that the discussions at the multidisciplinary team meeting were countermanded and they note that post-discharge follow-ups show a number of reviews by Doctor F where they document a good outcome with minimal reference to the events around surgery and no suggestion of an explanation or apology to the patient or family. Independent Expert A notes that the complication in question was not covered by the consent form or the documented consent process.

31.3. In relation to **Patient D**, Independent Expert A criticises the following aspects of the care provided:

(a) this was a case of major complication leading to potentially life threatening consequences;

(b) the preoperative consultation notes are brief and inadequate;

(c) the consent is inadequate and does not cover many of the common or serious complications including the one in question;

(d) the procedure was performed to a substandard level with multiple misplaced screws. One of these screws caused severe life threatening haemorrhage due to direct vessel damage;

(e) the patient suffered further distress and health issues requiring later admission; and

(f) the failure to review and debrief a patient and family after such an event as being unacceptable and unprofessional.

31.4. In relation to **Patient E**, Independent Expert A refers to a potential probity issue about the recording of adverse events. They refer to the question of inadequate monitoring, which they say highlights the persistent finding of poor preoperative documentation by Doctor F across their practice at that time.

31.5. I accept Independent Expert A's expert evidence and, in the absence of any evidence to the contrary, I adopt their findings within my conclusions. The recently published SPSLBR identified harm in cases falling within the remit of my investigation, I adopt these findings.

32. **The Disciplinary Investigation**

32.1. I have extensively examined the disciplinary process that led to the eventual dismissal of Doctor F. I have examined the contents of whistleblowing letters sent to the GMC and to the Trust. I understand that, because of the whistleblowing letters sent to the Trust, the Trust

determined that it was required to undertake an investigation in accordance with a framework known as “Maintaining High Professional Standards in the NHS”.[5] The remit included investigating concerns about operative performance and outcomes, inappropriate behaviour towards staff and patients, and inappropriate influence on operational and governance systems within the Trust. The thrust of the whistleblowing letters in August and September 2014 related to Doctor F inconsistently running, and self-policing, the governance structure, manipulating processes, delivering a lower standard of care, bullying, and substandard surgery.

32.2. Allegations were also made of inappropriate sexualised behaviour, which led to Doctor F’s dismissal. It was these allegations that were taken forward to the disciplinary hearing, rather than any allegations of harm to patients, because they were at a more advanced stage in the investigation process. In my view, this action of taking forward these allegations was appropriate.

32.3. I have raised some concerns in relation to the disciplinary investigation itself and found that certain matters could have been investigated more thoroughly prior to taking the decision to proceed with the sexualised allegations in isolation. I acknowledge, however, that it is likely that certain matters were not fully investigated, as the investigation was not complete by the time that a decision was taken to proceed only with the sexualised allegations.

32.4. The other allegations (namely, the concerns around patient care) should have continued to be investigated by the Trust, even though they did not proceed to a disciplinary investigation. This is confirmed by the Trust’s own policies, including the whistleblowing policy, and

[5] https://webarchive.nationalarchives.gov.uk/ukgwa/20130123204228mp_/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4103344.pdf

these investigations should have proceeded notwithstanding Doctor F's dismissal.

32.5. The death of Patient A is an illustrative example in this regard:

(a) Allegations regarding patient care in relation to Patient A were made in 2014 and should have been investigated by the Trust but they were not.

(b) Once Doctor F was dismissed in respect of the sexualised allegations, the remaining allegations were passed to the GMC for investigation and the RCS review was commissioned. In my view, this action was appropriate.

(c) However, at the material time the Trust had its own internal policies in place, such as a bullying and harassment policy, a whistleblowing policy, and a staff charter. In my opinion, irrespective of any GMC investigation, the Trust had a duty within its own policies to investigate the allegations which had been raised in various whistleblowing letters, together with any material allegations raised during the disciplinary investigation.

(d) The Trust did not investigate these matters internally after the dismissal of Doctor F. The Trust, in accordance with its own internal policies owed a duty to those making the complaints to investigate these issues thoroughly and properly and in accordance with its own policies. Therefore, allegations concerning the clinical practice of Doctor F,[6] governance manipulation or bullying and harassment, were not thoroughly investigated following the dismissal of Doctor F, when in my opinion they should have been.

[6] Note that there was at the time some investigation into this aspect both before and after Doctor F's dismissal, but not a detailed investigation when compared to Independent Expert A's investigation or the Doctor H Report, for the reasons stated.

(e) In my view, the members of staff who made the allegations felt quite rightly let down, because these allegations were not investigated internally, with appropriate feedback given to staff and appropriate conclusions reached. This added to the perception that Doctor F was being protected.

33. **Manipulation of governance**

33.1. My remit as stated does not require me to make any findings in relation to the manipulation of governance (for example, the deprioritisation of DATIX). The Trust has not carried out an internal investigation to satisfy itself that there was no manipulation of governance. No direct evidence has been presented to me of governance manipulation. However, I note that the recently published SPSLBR has identified suboptimal governance practices.

34. **Culture**

34.1. The Chief Executive ("Leader A") who had started in the Trust in 2001 implemented a series of measures to greatly improve the Trust's functions for both patients and employees. The work undertaken by Leader A was extremely impressive.

34.2. Prior to the first whistleblowing letter, Leader A was not aware of any allegation relating to Doctor F. They are dismayed that staff felt they could not speak up.

34.3. During the Relevant Period, the Trust undertook significant change, including the merger between Salford Royal NHS Foundation Trust and the Pennine Acute Hospitals NHS Trust and the formation of the NCA. The overall culture of the Trust was demonstrated in various reviews and performance indicators. Under the leadership of Leader A, the Trust introduced many measures such as the Quality Improvement Strategy and the implementation of the Salford Standards 7 day services.

34.4. I have had sight of information that shows that there were many policies and measures in place, not only in respect of patient safety and outcome but in respect of staff satisfaction and importantly the "Freedom to Speak Up". I have seen evidence that the Trust was in the top 10 of NHS Trusts on a composite measure of managing NHS hospital consultants. I have considered the following evidence:

(a) the Trust had consistently high levels of staff engagement, with a national report (2010-13) citing the Trust's concept of devolved decision making to senior clinicians; its method of continuous improvement; and its involvement of staff and stable senior leadership;

(b) the Trust scored within the top 10% of hospitals in the NHS for staff engagement and a national report evidences from 2017 onwards that the Trust scored better than average in questions asked about engagement and morale. Specifically, the evidence shows that staff reported that compared to national averages, that they felt secure in raising concerns about unsafe clinical practice; that they were confident that the Trust would address concerns; and were able to speak out about anything that concerned them in their organisation. The report also demonstrated that the Trust was better than most organisations on the measures of harassment, bullying and abuse at work from managers and colleagues;

(c) specific actions on improving the culture in operating theatres;

(d) a review of leadership arrangements concluded the Trust as being 'well led';

(e) following the CQC inspection in 2015, the Trust was the first acute Trust that held an 'outstanding' rating, but no longer holds this rating; and

(f) I have seen documentary evidence showing that the Trust had better indicators of organisational-wide leadership, culture and governance than would be found in most other NHS Trusts.

34.5. It cannot be said that systems were not in place; indeed, it appears great efforts were made to ensure that the Freedom to Speak Up was fundamental to the organisation. However, it is clear from comments provided to me and during the initial investigation in 2014, that the staff had a different perception, principally within spinal surgery.

34.6. Regarding the overall culture, at the relevant time, I limit my views to that of the spinal division and not of the whole organisation. While it has to be accepted that systems were in place for staff to report concerns, the BSG's perception was that they could not raise concerns. The BSG believed that they were unable to take advantage of the measures in place allowing them to report concerns because of the relationship between Doctor F and Manager A, and because of the way Doctor F had treated colleagues.

34.7. It must be accepted that Doctor F did not hold the power that they purported or was perceived to have, but the BSG believed that they did have that power. That impression was certainly present within the small division of spinal surgery. Staff reported that they feared for their position if they spoke up. They clearly held the view that no matter how they 'spoke out' about their concerns, this would be reported to Doctor F as head of the division, and they would suffer the consequences. I should state that Leader A, as Chief Executive at the material time, was not aware from the evidence that I have seen that this perception was present.

34.8. In relation to current culture within the Trust, amongst those I have interviewed, there remains a perception of mistrust of senior management. This arises from the multiple issues raised, the suggestion of inaction by the Trust, and the concealment of the circumstances of Doctor F's dismissal. The observations of an

individual ("**Manager E**"), as I have set out in their interview with me, are concerning, in particular their description of the culture within spinal surgery as being "*broken*".

34.9. My understanding is that more confidence has been restored by reason of the fact that the present Chief Executive has instructed me to investigate these issues, and by their support of the process. Trust needs to be re-established; relationships need to be restored. Staff need to be reassured that the policies in place will protect staff from any bullying behaviour, that complaints will be investigated, and that there will be transparency.

35. **Concerns of BAME individuals**

35.1. During interviews with some individuals from a BAME background, I was extremely troubled to hear that they believed that the Trust was and remains racist. This issue cannot and must not be ignored. The Trust should engage with these colleagues to understand why they have come to this conclusion, and to ensure that any such behaviour, if apparent, is stamped out and never repeated.

36. **CQC observations**

36.1. On 3 January 2023, I received an email from a consultant ("**Doctor X**"). This email expressed concerns held by them and their colleagues ("**Doctor I**", "**Doctor G**" and "**Doctor V**") regarding the current and historical practices of appointing senior Medical Managers within the Trust.

36.2. Attached to Doctor X's email was a document which includes statements from a recently published CQC report regarding the Trust (the "**CQC Report**"). The CQC Report details concerning observations made by both staff and management regarding the culture and behaviours within the organisation:

(a) A recurring theme by staff was their inability to speak out and the lack of response by senior management when they do so.

(b) There was a belief that senior management were not visible or approachable. The impression is that there is a culture of ‘us and them’. Management were perceived to be in position for life and appear to be disproportionally close to colleagues in similar posts.

(c) There were reports of long-standing issues with senior clinical leaders that have been apparent for several years. Senior clinical leaders continued in their posts despite significant failures.

(d) Although current leaders may maintain that issues are historical and have been dealt with, what might be viewed as historical structures, behaviours and individuals continue to be a real and present threat to the organisation.

(e) A complaint was made by staff of a lack of opportunity to contribute to decision making and help avoid pressures, thus compromising the quality of care.

(f) Some senior appointments and important decision-makers appear to reflect self-interest and self-preservation, rather than the interests of the Trust. In particular, the culture was one of fear and intimidation due to the closeness of Doctor F and Manager A.

(g) There was a pervasive belief that the above issues have never been acknowledged as being an issue by management.

36.3. The CQC Report goes on to detail potential improvements and mechanisms, which in their view, would ensure independence and suitability of senior leaders and managers.

36.4. The views expressed are of serious concern and should be actively considered by the Trust. I have made some observations in relation to the appointments process within my recommendations. As I have said above, trust needs to be restored. Individuals need to have confidence in senior clinical leaders. The Trust needs to engage with concerned individuals to mutually find a way to resolve and work through the concerns expressed.

Overall conclusions and recommendations

I make the following recommendations:

37. **BSG**

37.1. Members of this group feel aggrieved and disappointed with the way they have been dealt with by the Trust. Some of the individuals have attempted to speak out about concerns for themselves or others and have been met with resistance and inaction. There is merit in their view that the BSG has been failed.

37.2. Members of staff and surgeons were not informed of the basis of the dismissal of Doctor F until 2021, six years after their dismissal. Because of the lack of information being shared surrounding Doctor F's dismissal, members came to their own conclusion, and believed that Doctor F had been "*paid off*." This is in the context of a group of individuals who had felt bullied and mistreated by Doctor F, it therefore strengthened their perception that they were "*untouchable*." There was a perception that Doctor F was being "*protected*" by senior management.

37.3. I have considered suggestions that governance had been manipulated by Doctor F and or Manager A. Whilst I have not seen specific and clear evidence of this, as a result of interviews of various staff members, there is certainly an inference of manipulation and an inference that complications, DATIX and concerns were not progressed as they should have been. Furthermore, there was a clear

perception that Doctor F was being protected by Manager A, and that they together either bullied staff or, as above, manipulated governance processes. The Trust did not investigate this at the time.

37.4. The culture that existed in my view eroded the trust and confidence of staff in this division. Taking these and other factors into account, it is little wonder that members of the BSG felt let down and believed that Doctor F was being protected.

37.5. Further, the split in the investigations of Doctor F between sexual allegations (for which Doctor F was subject to disciplinary proceedings and dismissed) and concerns around patient care is another example of how the BSG felt they were not listened to, given they had repeatedly, and futilely, blown the whistle on such issues. This significantly eroded the confidence that staff and in particular the 'BSG' had in senior management.

37.6. Members of the BSG were not advised that they had been listened to, there was no opportunity to discuss concerns, nor were they given any reassurance that the concerns would be dealt with. The Freedom to Speak Up process failed them.

37.7. Left without clear information and/or support, it is understandable the feelings of disappointment, upset, anger and apathy have fostered negative beliefs. For this, I believe that the members of the BSG are owed an explanation and apology.

38. **Governance**

38.1. I understand that the DATIX system has evolved and now tracks actions and input from individuals. Taking into account the concerns voiced, users would benefit from comprehensive guidance about the channels and steps that determine what should and should not be filed using the DATIX system. From the examples that I have seen, the information contained in the system can be somewhat limited and it can be difficult to follow the chain of events.

38.2. I believe that the digital systems that are in place have the capacity to capture and store all the relevant information, documents, and reports. Use of the central storage of all relevant material, does not appear to be demonstrated. I am told that while letters and notes of meetings with family members dealing with, for example, the duty of candour, may be stored in some capacity, there is no uniform approach and they are not centrally recorded.

38.3. I am told that, for example, in the case of Patient A, there is no record of a multidisciplinary team meeting or what was agreed and discussed there. This is something that should be readily available.

38.4. There is a need for a robust recording system with the function to record who made changes and why. The Trust should put in place a system that allows and keeps records of all discussions and documents including Rapid Reviews (currently not in the DATIX system) and multidisciplinary team meetings. Where DATIX are downgraded, the reason for this and who made that decision needs to be recorded. This also applies to any form of patient review in relation to a particular surgeon. For example, had the work of the spinal surgeon been recorded in a central system, it could have been viewed in 2016 by multiple individuals, which could then have impacted upon the Trust taking action earlier.

38.5. I am aware of the function of the Morbidity and Mortality meeting and the Rapid Review process. However, as I understand it, none of this is recorded centrally. The contents of Morbidity and Mortality meetings should be recorded in the same system to allow easy access and recovery of data when and if required in later years. If adherence to such a system was strictly enforced, then there would not be the situation, as in the cases of Patient A and Patient C, where Morbidity and Mortality meeting notes were not stored.

38.6. Of course, the completion and adherence to protocol would require supervision and oversight.

39. **Senior leadership and appointments**

39.1. Whilst there is no specific evidence, certain individuals have described to me what amounts to an undercurrent of cronyism. I am told (albeit without verification) that individuals are being placed in roles as a result of the grace and favour of close colleagues. There is a perception that the appointments process is not transparent. The views as expressed to me in Doctor X's email, set out above, need to be taken into consideration.

39.2. It may be desirable for the Trust to set out a description as to the roles of the leadership team within each division, providing job descriptions. The Trust should consider undertaking regular appraisals of the leadership team, including '360 degree' appraisals (whereby junior colleagues review the performance of their senior colleagues). Perhaps appraisals of senior leaders could be conducted by someone outside of the division to allow for a degree of independence.

39.3. This perceived cronyism resulted in legitimate and real concerns not being raised due to a perceived lack of independence and accountability. Any measure afforded to the staff to 'speak up' was met with mistrust and suspicion. Systems need to be put in place to ensure transparency, and that any appointment made is done so on merit.

39.4. When considering the specific division of spinal surgery, I am told that the fact that the Chair of Division was also a surgeon in that speciality made it difficult for staff to raise concerns. Colleagues would be filing DATIX specifically about Doctor F or their practice knowing that this would be seen by Doctor F. The approach suggested to me is more favourable, in that a Chair of Division should not also be a surgeon in that same division, but from a different specialty.

40. **Patients and family members**

40.1. I have considered worrying opinions and commentary, in particular in the Doctor H Report and the evidence from Independent Expert A, in relation to the clinical and surgical practice of Doctor F, and the findings and conclusions of the SPSLBR. I rely on the expertise of these individuals and particularly the expert opinion of Independent Expert A, whose opinions I adopt.

40.2. It is clear that there is evidence that certain patients have, at worst, suffered avoidable harm and, at best, received substandard care.

40.3. In each of the cases mentioned, the patients and/or their families should receive a full and transparent explanation and an apology for the level of care they received from Doctor F and the Trust. In relation to Patient A, I understand that the family have now at very long last been provided with the RSUI Report and an explanation has been provided to them, 16 years after their tragic death.

41. **Investigations**

41.1. In my view, disciplinary investigations require the expert input of Human Resources.

41.2. It is imperative that the Trust's own policies are complied with, and that allegations are fully investigated, particularly if they fall within bullying, whistleblowing, or the staff charter. Any individual who is appointed to be a case manager or investigator needs to be trained on how to conduct such a role and be guided by Human Resources on the framework of the investigation, and the relevant policies. In my view, such investigations should be led by Human Resources.

41.3. My understanding is that Doctor F has been referred again to the GMC.

42. **Concerns relating to BAME employees**

42.1. It has been reported to me that certain members of staff believe that there was, at the time of Doctor F's tenure, an undercurrent of racism. There is also a perception that this racist culture continues to exist.

42.2. My remit was not to investigate if this was correct, and I have not done so. In my view, however, the Trust needs to explore with colleagues why concerns have arisen and what the Trust can do to restore confidence. This is an issue which must be dealt with.

Reflection

43. Lessons need to be learnt from these unfortunate events.

44. Those involved who have been criticised should reflect upon their actions or inactions.

45. The Recommendations of the SPSLBR need to be robustly adopted.

Carlo Breen

9 St John Street Chambers

5 March 2024