Review of NHS Tayside's Investigation of Professor El-Jamel

At the request of Annie Ingram, Deputy Chief Executive of NHS Tayside, I attended on the 23rd November 2018, having been provided with a number of documents in advance and the Terms of Reference, to speak to staff as arranged

The Terms of Reference are set out here.

Terms of Reference

- To undertake a desktop review of NHS Tayside's handling of the case involving Professor El-Jamel to determine whether the action taken by the Board was reasonable, timely and appropriate.
- This should include a review of the timeline of events; a review of the Board's handling of complaints and the action taken.
- The Review should identify any questions to address as a consequence and/or to establish if any further data should be sought and should identify areas for improvement.

The documents I was provided with are as follows:

- Concerning investigations of the incidents and complaints:
    - A spreadsheet of patients involved in the recall exercise.
    - The significant clinical event analysis (2012, case 33) and the tabular timeline used as part of the root cause analysis.
    - Details of the adverse events contained within the Datix system printed in October 2018.

- Concerning the investigation of the individual:
    - A letter from Mr Philip McLaughlin to Professor El-Jamel dated 21st June 2013.
    - The interim letter from the Royal College of Surgeons dated 4th October 2013.
    - The final report from the Royal College of Surgeons dated 6th December 2013.
    - A letter from Dr Andrew Russell to the GMC (Mr Willie Paxton) dated 20th December 2013.
    - A letter from Dr Andrew Russell to Professor John Connelly in his University role dated 17th February 2014.
    - A letter from Dr Russell dated 17th February 2014 to the GMC explaining that in view of Professor El-Jamel's notification of intention to retire, NHS Tayside was not pursuing a formal investigation.

- Details of the GMC entry and conditions place on the registration of Professor El-Jamel from 26th February 2014.

- NHS Tayside's reflections and learning:
  - A letter from Dr Lee Jordan concerning his initial and final observations.
  - The SBAR briefing provided to the Chief Executive and Chairman dated 1st August 2018.

I attended and interviewed four members of staff between 10.30 and 15.00hrs, Mr David Mowle, Mrs Tracey Pathway, Mrs Audrey Warden, and Mr Eric Ballantyne.

Observations and Recommendations

1. Both neurosurgeons described a relatively close knit unit with four consultants, and a small number of trainees working in a collaborative fashion. Professor El-Jamel was a good colleague, willing to swap on-call, and keen to develop the profile of the Unit with academic publications but worked in a rather hierarchical manner. The morbidity and mortality processes within the Unit were established, with an expectation that post-operative complications, readmissions, returns to theatre, and in-patient deaths would be discussed. However both observed that this required individual surgeons to identify cases proactively, and both observed that normal processes can be subverted and bypassed if an individual is determined to do that and reflected that this had occurred in this situation, but not been apparent to them at the time.

2. Dr Jordan's review of events and the timeline is clear and raises a number of points for NHS Tayside to consider. I have attempted not to duplicate these. The issue of appraisal is considered within this, and consideration given to the processes that support the visibility of complaints to the appraiser and Clinical Lead. I also note these events took place in the first complete year of the first cycle of revalidation at a time when most organisations had less well developed processes. Appraisal is fundamentally dependent on the openness of the appraisee in their submitted documentation and in the quality of the subsequent discussion, as well on the detail with which the Form 4 is completed by the appraiser. It is not a system that will identify a doctor determined to deceive nor prevent substandard practice. I am also aware of the governance review requested by the Cabinet Secretary prompted by this case about the visibility and escalation of complaints and the triangulation with appraisal and the work undertaken by all Boards to articulate their processes and strengthen these.

Recommendation: NHS Tayside might consider their current processes and test out whether they believe and can evidence that these events would be identified earlier or handled differently

3. Professor E-Jamel had a defined role of the Chair of the Clinical Governance Committee, and this influenced Board reporting, and allowed him to promulgate his own views. Additionally I note that Professor El-Jamel attended the Significant Adverse Review into the wrong site surgery of patient [redacted] (case 33). It is clear from comments made that this influenced the direction of the discussion, and may have weakened the findings of the SAER.

Recommendation: NHS Tayside should consider its SAE policy and whether there are opportunities to strengthen this, and to consider the effect on the investigation of participation of individuals responsible for the care of the patient in a roundtable type approach.

4. <u>Interactions with Trainees</u>

Professor El-Jamel had significant opportunity to influence the career directions and development of trainees and had an expectation that he would always be provided with a more senior trainee when on-call. His habitual practice was to undertake the operations if he was in theatre, or if he had a sufficiently senior trainee, to leave them to operate in an unsupervised fashion. Additionally he did not tend to see patients himself in the out-patient clinic but used a central room as a hub where trainees reported back to him on patients they had seen. Examples were given of trainees expected to undertake additional on-call on an informal basis to cover more junior trainees. Various pieces of feedback were given to Deanery colleagues regarding training opportunities and behaviours but given Professor El-Jamel's academic influence, trainees were fearful of causing offence. Neurosurgery is a small specialty at a UK level. Additionally, at various times there have been considerations about the number of neurosurgery units required in Scotland, and the viability of individual units is influenced by trainee experience and reports.

Recommendation: I have not undertaken detailed examination of any focus groups held with trainees, or individual pieces of feedback, but would recommend that NHS Tayside has a clear system in place to ensure that any adverse or concerning comments identified by trainees regarding individual consultant behaviour in any specialty have a level of visibility within the organisation rather than solely within an educational line.

5. Patient Recall Exercise

Following the review of the Royal College of Surgeons, a patient recall exercise of approximately 150 patients was undertaken. As far as I can determine this was undertaken within the Department with little, or no additional resource, and involved a very significant effort on the part of the General Manager and Mr Mowle, with little or no additional administrative resource, very significant emotional and clinical additional burdens in reviewing concerns from anxious, and occasionally angry patients. A clear recall structure around the clinical questions was identified and is set out in the briefing note.

Recommendation: Should a patient recall need to be undertaken of any significant volume then a formalised structure (such as an incident management team approach) should be used for this to provide structure, additional resource, and oversight, through a formal reporting mechanism.

6. Restriction and Supervision of Practice

Following the fourth and fifth complaints received about Professor El-Jamel's practice in June 2013, moves were made to restrict Professor El-Jamel's practice, and the Royal College of Surgeon's review was commissioned. The restriction of practice was discussed and summarised in a letter by Mr McLaughlin but put into practice by Mr Mowle. At this stage there was no substantiated evidence regarding the scale of the issue, or an understanding that events may have been dealt with less than transparently by Profession El-Jamel. It is my experience that investigating concerns raised about the practice of a colleague is always difficult, and actions taken need to be proportionate and with appropriate consideration for confidentiality. If an investigation does not substantiate a cause for concern, then individuals may complain if they believe their reputation has been unfairly called into question. For this reason Mr Mowle was right to be sensitive about how colleagues on the ward, and trainees might perceive a restriction to Professor El-Jamel's practice. However, I note that there existed a level of ambiguity and mixed understanding about those restrictions which with hindsight, when the College of Surgeons produced an interim and final report substantiating the concerns, left some missed opportunities for closer supervision. The e-mail provided by Mr Mowle to Professor El-Jamel on the 25th June 2013, described joint ward rounds and case based discussions. The e-mail clarified that Mr El-Jamel would continue with his on-call duties, and emergency cases would be discussed during the post operative ward round. Professor El-Jamel was copied into the e-mail. What was not in place, and neither neurosurgeon I spoke to believed this was ever discussed, was any direct supervision of Professor El-Jamel's practice in the operating theatre. However the phrase restriction of practice and supervision of clinical practice for a surgical

consultant could well be inferred to include direct supervision of operative practice by others including other clinicians and managers. Indeed during this period of restricted practice, further clinical incidents occurred including one case of wrong level surgery subsequently identified and one case where deliberate obfuscation of the procedure undertaken and the consequences for the patient occurred. At the time there were no procedures in place, and this had not been the intention of the restriction, to allow consultant neurosurgery colleagues to have direct involvement in intra-operative care and they were reliant on the word of Professor El Jamel about his actions in theatre.

Recommendation: In the future should NHS Tayside have cause to restrict or place a consultant under similar conditions, I recommend there is greater clarity about what is meant by restricted practice. There is clearly a balance to be struck between confidentiality and acknowledgement that during a process of investigation concerns are being explored and may not be substantiated, and the need to ensure that the safest possible patient care is undertaken.

7. <u>RCS Report</u>

The College of Surgeons provided a letter following their visit on the 16/17th September. That letter is dated the 4th October 2013. It is not clear to me whether any verbal feedback was provided on the day but they did not speak to Professor El-Jamel himself until the 2nd October 2013. They raised concerns regarding a number of cases of wrong level surgery, lack of openness with colleagues, and lack, of openness with patients. The review team gave some specific instructions about what they understood supervision would mean, but given that a further wrong side surgery occurred in a patient between the interim and final report from the RCS, this illustrates the difficulty with ambiguity about the conditions of restrictions (outlined in point 5). There was no verbal communication of the interim letter with its explicit recommendations to the clinical lead in the unit or the General Manager.

Recommendation: With appropriate regard to the duty of care owed to individuals, NHS Tayside should consider how to ensure that appropriate dissemination of such reports is undertaken, with discussion of necessary actions with clinical teams, for subsequent reporting for oversight and assurance at the relevant governance committee.

8. <u>Voluntary Erasure from the GMC Register and Cessation of the Internal Investigation</u>

I have not been able to speak to Professor Russell, and therefore it is difficult to know exactly in what order decisions were made. Whilst it can be difficult to complete a difficult internal investigation when an employee is not at work, and Professor El-Jamel was suspended on 10th December 2013, I am not

aware of any Occupational Health status that said he was not fit for an investigation to continue. Whilst the GMC had imposed interim conditions on his registration, once voluntary erasure proceeded, unopposed by NHS Tayside, the GMC has no legitimate locus to continue with a Fitness to Practice Hearing. The reasons why NHS Tayside did not oppose Professor El-Jamel's application for voluntary erasure are unclear as this could have been done when he subsequently indicated that he intended to apply for early retirement. There has been a significant change in personnel in NHS Tayside, and one would expect this level of decision to be made at an Executive level. The role of the Chair in any discussion is also not clear as he has been written to in a University capacity rather than as the Chair of the Board. The GMC have also reinforced their processes and if they are investigating concerns through their own processes, they will not process an application for voluntary erasure.

Recommendation: The Responsible Officer in NHS Tayside is notified when any doctor connected to them applies for voluntary erasure through current processes and there is a short period (ten days) to indicate to the GMC that there are concerns under investigation to ensure that voluntary erasure does not proceed. I recommend that the RO reviews internal processes to ensure that any necessary action to communicate with the GMC can be taken within the short timeline

9. <u>Timelines and whether the action taken by the Board was reasonable, timely and appropriate, including handling of complaints</u>

The initial complaints received were complex and appear to have been adequately investigated, although I refer to my earlier comments above about the operating surgeon being part of the significant clinical event analysis for one complex complaint. Speaking to members of the clinical team, it was only when a number of complaints were received, and a theme began to emerge of less than transparent explanations given to patients, that greater concerns were raised. Although with the benefit of hindsight one can perceive a pattern, I do not believe that there was any evidence that NHS Tayside failed to act on in a timely way that was obvious at the time.

TRACEY GILLIES
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8th April 2019