



Revalidation Support Team



National Clinical Assessment Service

Case investigator training programme

SAMPLE INVESTIGATION REPORT

This programme has been prepared by
the RST and NCAS working in partnership

This report has been produced as an example investigation report, based on NCAS/RST templates, to support the case investigator and case manager training and networking events in 2012 and 2013. Dr Purple and the circumstances described in this report are entirely fictional and any similarity they bear to any doctor or case investigation is entirely coincidental.

Investigation report

Organisation's name: St Elsewhere's Hospital Trust

Report of investigation into concerns raised in relation to Dr Purple

Organisation's case reference number: XYZ123

Date: 25 March 2013

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1. Introduction

- 1.1. This report describes the background, process, findings and conclusions of an investigation into concerns about Dr Purple's behaviour and clinical practice.
- 1.2. The investigation has been undertaken following the Trust's policy HR05, Policy for managing conduct and capability concerns in doctors and dentists, and the associated guidance. This policy follows the national guidance set out in 'Maintaining High Professional Standards in the Modern NHS' (Department of Health, 2005). The Trust's local policy HR01, Policy for dignity at work and the management of harassment and bullying, and the policy CP01, Policy on disposing of sharps directly, have also been consulted.
- 1.3. The investigation team is not aware of any concurrent investigations being undertaken with regard to Dr Purple either within the Trust or by any external bodies.

2. Background

2.1. Dr Purple has been employed as a Consultant Cardiologist within the Trust since January 1985, a total of just over 28 years. When he joined the Trust he was one of two Consultant Cardiologists but since then the department has expanded to a total of six whole time Consultants with an associated medical staff of three Specialist Registrars, a FY1 doctor and an Associate Specialist. A GP also undertakes one session per week in the department as a clinical assistant.

2.2. A number of new techniques have been introduced within the department since Dr Purple joined the department including cardiac catheterisation, which was introduced in early 2000. Dr Purple was instrumental in getting the catheter lab approved and developed as he had previously been attending at St Anywhere's Hospital once a week to undertake catheterisation procedures and maintain his expertise.

2.3. Dr Mauve, Medical Director and Case Manager, commissioned this investigation after concerns about Dr Purple's behaviour and a number of clinical incidents were drawn to his attention. The terms of reference (TOR) for the investigation as set out in Dr Mauve's letter of 22 January 2013 (Appendix 1) were:

'The matters to be investigated are:

TOR1. The circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 15/11/12 (incident no 1462)

TOR2. The circumstances related to the complaints from a patient about shouting at staff on wards on 21/11/12

TOR3. The circumstances related to the complaint from the trainee about Dr Purple stating that she will never make a cardiologist

TOR4. The circumstances relating to the two incidents in the catheter laboratory:

a. Patient no 12345 where vascular access was difficult to find

b. Patient no 67893 where there was difficulty with a pacemaker insertion

It is expected that the investigation will be completed by 19/03/13 and that a report will be submitted to Dr Mauve by 26/03/13.'

3. The investigation

- 3.1. The investigation was led by Dr Neon, Consultant, MB BS, FRCA, MBA who is a Consultant in the Trust in a different division from Dr Purple. Dr Neon has undertaken training in Case Investigation and Case Management provided by the NHS Revalidation Support Team and the National Clinical Assessment Service in January 2013 and has previously completed 10 investigations within the Trust in the last four years. Dr Neon has also provided expert clinical opinion to investigators in two other Trusts and has had experience of sitting on disciplinary panels. In the last five years Dr Neon has also attended four one-day seminars provided by legal firms relating to writing medico-legal reports and case investigation.
- 3.2. Dr Neon was assisted in the investigation by Ms Orchid, Associate Director of HR, MCIPD, who has supported 12 investigations in the Trust in the three years she has worked at St Elsewhere's.
- 3.3. Neither Dr Neon or Ms Orchid have previously been involved in any investigation or disciplinary procedure involving Dr Purple and both declared that they have no known conflict of interest in undertaking this investigation and that they know of no reasons why there should be any perception of bias.
- 3.4. The initial terms of reference (TOR) were as described in 2.3 above.
- 3.5. The letter from Dr Mauve asking Dr Neon to undertake the investigation (Appendix 1) also stated that 'Dr Purple does not dispute that he left the ward round on three occasions to cover his colleague Dr Crimson at the second St Elsewhere Hospital site'. Dr Neon met with Dr Mauve on 25/01/13 to confirm that Dr Mauve did not want this matter investigated. At the same meeting Dr Neon also questioned the requirement in the letter 'to provide a commentary on how the performance of Dr Purple compares with that expected of a doctor working in similar circumstances' as this might be perceived as too general a requirement when the clinical incidents had not yet been fully investigated. Dr Mauve agreed to remove this requirement.
- 3.6. Dr Purple was notified of these changes in a letter sent on 25/01/13 (Appendix 2).
- 3.7. The final agreed terms of reference and the matters to be investigated were then:
- TOR1. The circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 15/11/12 (incident no 1462)
- TOR2. The circumstances related to the complaints from a patient about shouting at staff on wards on 21/11/12

TOR3. The circumstances related to the complaint from the trainee about Dr Purple stating that she will never make a cardiologist

TOR4. The circumstances relating to the two incidents in the catheter laboratory:

- a. Patient no 12345 where vascular access was difficult to find
- b. Patient no 67893 where there was difficulty with a pacemaker insertion.

3.8. Dr Mauve also provided the investigation team with an initial bundle of information to consider which comprised:

- Policy CP01, St Elsewhere's Policy on disposal of sharps correctly
- NICE guidelines on disposing of sharps correctly
- Policy HR01, Policy for dignity at work and the management of harassment and bullying
- Incident report no 1462 (needle stick injury)
- Complaint letter from patient dated 21/11/12
- Complaint from trainee dated 22/11/12
- Complaint from Director of Medical Education dated 27/12/12
- Incident notification: 12345 (Vascular access was difficult to find)
- Incident notification: 67893 (Difficulty with pacemaker insertion)
- St Elsewhere's Needle Stick Injury Report for FY11/12.

3.9. Shortly after starting the investigation a letter was forwarded to Dr Neon by Dr Mauve; this letter, dated 23/01/13, had been written by Dr Cerise in support of Dr Purple. This letter has been included in the appended evidence at Appendix 3, but as it relates generally to Dr Purple's character and does not relate directly to any of the specific allegations it has not been reviewed further and Dr Cerise has not been interviewed.

3.10. An initial list of interviewees was identified from the documentary evidence and, following initial interviews, further potential witnesses were identified. Dr Purple was notified of the initial list by letter and e-mail on 26/01/13 and was notified of the additional interviewees, again by letter and e-mail, on 18/02/13.

3.11. Dr Purple was invited for interview twice and attended both interviews; on the first occasion he attended unaccompanied and on the second occasion he was accompanied by his Medical Defence Organisation representative (Mrs Mint). He had been made aware by Dr Mauve and in both invitations to interview that he could be accompanied.

3.12. The interviews were all held in the HR Quiet Room as this room cannot be seen into and conversations within it cannot be overheard. All interviews were carried out by Dr Neon, accompanied by Ms Orchid. Detailed contemporaneous notes were taken by Mr Khaki from the HR department who is a trained note taker. Interviews were not recorded electronically. Following the interviews transcripts and statements were prepared and returned to the interviewees for confirmation and signature. All

interviewees were reminded of the requirement to maintain confidentiality and were made aware that they could be asked to appear as a witness at any future proceedings; all signed the standard HR form agreeing their understanding and agreement to this (example at Appendix 4). All interview transcripts and statements are attached within Appendix 3.

- 3.13. During the course of the investigation evidence came to light suggesting that Dr Purple might have health issues and this was referred back to Dr Mauve.
- 3.14. There were also allegations made during the interview with Staff Nurse Red (Appendix 3 – Item N) that Dr Purple may have taken medication for his own use from the ward medicines cupboard and may have prescribed an excessive dose of bisoprolol for a patient; these allegations were also referred back to Dr Mauve as they were not within the remit of the investigation or the terms of reference.
- 3.15. The investigation was completed within the requested time period and the report was signed and handed to Dr Mauve on 25/03/13.

4. Methods

4.1. The letter commissioning the investigation and containing the initial terms of reference was received on 22/01/13. In the first week of the investigation the team reviewed the initial documentary evidence provided by the Case Manager, set up an index of evidence, determined what further documentary evidence would be required and requested it and determined an initial list of interviewees and invited them to interview. Interviewees were offered a variety of appointment times in a timetable included with the interview request letter. The initial list of people to be interviewed was:

- Staff Nurse Red
- Dr Orange
- Dr Maroon
- Dr Purple
- Dr Pink
- Patient Patterned.

4.2. Patient Patterned was approached by the Complaints Officer and asked if she was prepared to be interviewed; she was willing but unfortunately was leaving to go to visit her son in Australia the next day and was not expected to return for 6 months so she was not interviewed.

4.3. Following these initial interviews and the further consideration of the documentation additional potential witnesses were identified and attended for interview:

- Mrs Greenbank – Manager of the Cardiovascular department
- Charge Nurse Brown – Cardiology ward
- Dr Cyan – FY2 medicine (cardiology)
- Professor Malachite – Director of Medical Education.

4.4. After reviewing and indexing the documentation supplied the case investigator asked for further information which was provided by the Clinical Quality and Information department as follows:

- Sharps injury data for the year 2012-13 to date
- Root cause analysis related to incident 1462 (needlestick)
- Patient records for the patients involved in incidents 12345 and 67893
- Incident reports relating to the catheter laboratory, cardiology department and cardiology ward for the previous six months
- Any complaints relating to Dr Purple in the year 2012-13 to date
- Mandatory training records for all cardiologists with particular reference to sharps management training
- Sharps management Standard Operating Procedure for Operating Theatres and Catheter Laboratory.

- 4.5. Further information on procedures carried out in the Catheter Laboratory was provided by Mrs Greenbank.
- 4.6. With consent from Staff Nurse Red Dr Neon sought confirmation from the A&E Department and Occupational Health that she had attended for immediate and further management relating to the needle stick injury - TOR1. The circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 15/11/12 (incident no 1462).
- 4.7. Dr Neon visited the cardiac catheter laboratory during a session when it was being used by a Cardiologist not involved in the investigation to see how the sharps disposal process worked in practice (report at Appendix 5).

5. Fact findings

5.1. In the initial review of the evidence provided by Dr Mauve, the Case Investigator looked at the chronology of the alleged events and it was found that they all fell into two separate one week periods as below:

- a. 15/11/12 Incident 1462 – Needlestick Injury (TOR 1)
- b. 21/11/12 Incident of alleged shouting on ward reported by patient (TOR 2)
- c. 22/11/12 Alleged incident causing complaint from trainee (TOR 3)
- d. 09/01/13 Incident 12345 – difficult vascular access (TOR 4a)
- e. 14/01/13 Incident 67893 – difficult pacemaker insertion (TOR 4b)

The findings are now set out in relation to each term of reference separately.

TOR1. The circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 15/11/12 (incident no 1462)

5.2. The evidence available from the evidence of the interview with Staff Nurse Red (Appendix 3 – Item N, the first interview with Dr Purple (Appendix 3 – Item L) and the confirmation letters from A&E and OH (Appendix 3 – Item AA and Item BB) all support that the needle stick injury to Staff Nurse Red took place, corroborating the incident form 1462 (Appendix 3 – Item D).

5.3. The Trust's Policy, CP01, Policy on disposing of sharps correctly (Appendix 3 – Item A) states in section 2 that 'this document applies to all Health Care Workers' working within the St Elsewhere Hospital Trust'. The guidelines in the policy are contained in section 4. Paragraph 4.2 states 'All sharpsmust be discarded directly and immediately into a sharps disposal container at the point of use'. Paragraph 4.5 says 'In general, it is the responsibility of the person(s) using the sharp to dispose of it properly. Do not leave sharps for someone else to dispose of.' It is noted that this paragraph says 'in general rather than always' but also that it says 'do not leave someone else to dispose of'. Paragraph 4.11 says 'used sharps must never be carried in a receiver or on a tray they must be disposed of directly and immediately into a sharps container.'

5.4. The NICE guidelines on disposing of sharps directly (Appendix 3 – Item B) which were supplied to the investigation were considered but not used as direct evidence of appropriate procedure as they are clearly labelled 'Prevention of healthcare-associated infection in primary and community care' and the incident concerned was in secondary care. It was noted that there is nothing in them that conflicts with the policy CP01. An internet search for similar NICE guidelines for secondary care did not find a corresponding document.

5.5. The incident report 1462, completed by Staff Nurse Red, indicates that there have been previous issues with Dr Purple not disposing of needles directly. In her interview Staff

Nurse Red confirmed this and agreed that she had not completed incident forms for the previous episodes but that she had told her manager. On this occasion she had completed the form because she was injured.

- 5.6. The incident form 1462 and the root cause analysis report both say that the incident was caused by the needle having been placed in a kidney dish (receiver) and fallen into the drapes. All of the sharps were left for Staff Nurse Red to clear away. The needle in question was a small needle with a short length of suture material attached to it.
- 5.7. The Case Investigator attended the Cardiac Catheter Laboratory and looked at the facilities for needle disposal; Mrs Greenbank, Cardiovascular services manager was also present at this visit. The report of this visit is at Appendix 5. There was an adequate number of sharps disposal bins present in a variety of sizes to accommodate different types of sharp material. One large container was mounted secured on a moveable stand and had a large aperture so it could be moved close to the operator who could place sharps in it without contaminating themselves. The Case Investigator noted that they did not use or have sterile needle disposal devices (pads or containers) such as are used in the operating theatres; one of these devices could have made the needle involved 'safe'.
- 5.8. During his first interview (Appendix 3 – Item L) Dr Purple acknowledged that he had put sharps into the kidney dish and said 'I don't see the point in putting them into the bin myself – the nurse knows where I put them'. On questioning he did agree that the nurses had asked him on a number of occasions to use the proper disposal bin, but he said 'I don't see the point'. He also said that he, on a number of occasions, had told nurses to be careful when clearing up or moving things.
- 5.9. The St Elsewhere's Needle Stick Injury Report for 2011/12 was found to be incomplete and did not otherwise relate to the time of the incidents (Appendix 3 – Item K). A copy of the 2012/13 information to date was obtained; the only needle stick injury incident reported from the cardiac catheter laboratory is incident 1462.
- 5.10. A review of the mandatory training records for the cardiology consultants showed that Dr Purple had not completed his mandatory training for the current year and had not attended the training session provided when the current 'Policy on disposing of sharps directly' had been introduced in 2011. All other cardiologists' mandatory training was up to date.
- 5.11. It is also noted that actions have been identified which could improve the safety of sharps management within the cardiac catheter laboratory and Mrs Greenbank has undertaken to work with the operating theatre manager to identify the most suitable products for use in the area. Another issue which Mrs Greenbank is taking forward relates to concern about previous incidents not having been reported.

TOR2. The circumstances related to the complaints from a patient about shouting at staff on wards on 21/11/12

- 5.12. This complaint was submitted by a patient on the ward and describes behaviour which the patient observed on Dr Purple's ward round and when he was on the ward. It is not clear from the letter how much, if any of this behaviour was directly observed by the complainant and how much emerged in conversation with another patient. The complainant was approached and was willing to help with our enquiries but was unable to attend for an interview as she was leaving later that day to go to stay with her son in France for six months.
- 5.13. The other patient mentioned in the letter could not be interviewed as she was too unwell following a further hospital admission.
- 5.14. Charge Nurse Brown, the only male nurse on that ward, was interviewed (Appendix 3 – Item O). He confirmed that he was on duty on the ward on 21/11/12 and this was corroborated by the duty rota. In his interview he said 'Dr Purple is often quite loud' and 'He (Dr Purple) does often demand that things are done his way, rather than in the way agreed with the department – for example he wants his patient records all in a tray on the desk for him and not in the notes trolley'. CN Brown was not able to remember any particular incident related to the 21/11/12 and commented 'we're used to it – so we probably wouldn't notice every time he shouts'.
- 5.15. In her interview (Appendix 3 – Item N) Staff Nurse Red, who also works on the ward, said 'he is often short tempered with the nurses' and 'he shouts a lot - whichever area he is working in'. SN Red was not able to give any more specific information about 21/11/12 as she could not remember being at the ward round that day and thinks she may have been at occupational health at the time.
- 5.16. Dr Cyan, the FY2 in medicine who was working in cardiology at the time said in his interview (Appendix 3 – Item P) that he was not present at the ward round on that day as he was on a day off after nights on call; this was confirmed by the medical staffing officer in an email (Appendix 3 – Item Q). He did say in his interview that 'all of the trainees know you have to be perfect if you don't want Dr Purple to shout at you' and described him as 'the most difficult consultant I have had to work with so far'.
- 5.17. The St Elsewhere's Policy and Protocol for Dignity at Work and the Management of Harassment and Bullying HR01 (Appendix 3 – Item C) was also considered. This suggests in a flow chart in the introduction that members of staff keep a diary of any incidents and raise them with the alleged harasser or their line manager and that informal resolution such as mediation is considered before formal action. In the body of the policy at paragraphs 4.2 and 4.3 there are descriptions of possible forms of harassment or bullying. In paragraph 4.2.1 harassment is described as 'action,

behaviour, comment or physical contact which is found to be objectionable by the recipient or which causes offence and can result in the recipient feeling threatened, humiliated patronised or isolated. It can also create an intimidating work environment'. Paragraph 4.2.2 says that harassment may be persistent or may occur on a single occasion'. Bullying is described in paragraph 4.3 as 'offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient'.

5.18. In this investigation it was found that neither CN Brown nor SN Red had reported any issues of bullying or harassment formally and they had not kept any diary records of any such incidents (Appendix 3 – Items N and O). Mrs Greenbank, Manager of the Cardiovascular Department, said in her interview (Appendix 3 – Item R) that she had not received any notifications of bullying and harassment from staff, although she said 'I know he is loud and can be very demanding'. As the policy HR01 also indicates at paragraph 6.4.3 that staff could contact occupational health (OH) the OH manager was asked if they had any concerns about bullying and harassment of staff by Dr Purple; the response (Appendix 3 – Item S) indicates that they have had no specific complaints. The Policy HR01 also states at 6.5.1 that the HR department is expected to keep records following resolution of complaints of bullying and harassment; the HR department confirmed that they do keep records and have no records of any incidents of bullying and harassment involving Dr Purple.

5.19. HR01 also states in 7.1 to 7.3 that training is part of the Corporate Induction with an Essential Update every three years and refresher training in the intervening years. Para 7.3 states that all training is recorded on the ESR system. A report about the training received by Dr Purple, CN Brown, SN Red and Mrs Greenbank, Dr Orange and Dr Cyan was requested from the Learning and Development team. This report (Appendix 3 – Item T) showed that there was no record of Dr Purple ever undertaking the training, CN Brown had not completed his Corporate Induction at the date of the incident but has completed it since and SN Red and Mrs Greenbank were up to date with all of their Essential Training Requirements. Dr Orange and Dr Cyan were confirmed as having received training in the online training provided by the Deanery and mandatory for all trainees to complete.

TOR3. The circumstances related to the complaint from the trainee about Dr Purple stating that she will never make a cardiologist

5.20. This issue was raised to Professor Malachite, Director of Medical Education by Dr Orange, in a phone call on the day the incident allegedly occurred. She then confirmed the phone call in a letter to Professor Malachite on the same day, 22/11/12 (Appendix 3 – Item F). Professor Malachite then raised his concerns to Dr Maroon, Clinical Director of Cardiology and documented them in a letter to Dr Maroon on 27/12/12 (Appendix 3 – Item G). In the letter he mentions the issues about Dr Orange, and a more general concern about Dr Purple's attitude to trainees which he describes in his letter as

'unsupportive and patronising'; later in the letter he describes Dr Purple's 'bullying attitude'. Dr Maroon gave this letter to the Medical Director on 02/01/13 with an accompanying letter saying that he had discussed this with Dr Purple who had said he would apologise to Dr Orange.

5.21. On reviewing the documents the investigation was initially provided with it was noted that in Dr Orange's letter (Appendix 3 – Item F) she wrote 'At this stage, I do not want to pursue any direct action with Dr Purple'. Before proceeding to investigate this particular complaint Ms Orchid, Assistant Director of HR, met with Dr Orange and explained that an investigation had been commissioned and that the Terms of Reference included this incident and another complaint about Dr Purple's behaviour, and the Case Investigator would like to be able to include Dr Orange's letter in the evidence and would like to interview her. Dr Orange agreed to this and was then invited to interview in the same way as all other interviewees.

5.22. Dr Orange in her interview (Appendix 3 – Item U) said that on the ward round on 22/11/12 Dr Purple asked her a question about the aftercare of a pacemaker and said 'I had no idea what the answer was'. Later in the interview she described 'Dr Purple suddenly became aggressive, patronising and dismissive towards me...'. She went on to describe her feeling of 'humiliation'. In her letter (Appendix 3 – Item F) she had described being 'publicly humiliated' and being 'incredibly embarrassed'. Dr Orange was not able to confirm in her interview the exact words that Dr Purple had used, which in her letter on the day of the incident she had said were 'a hopeless and rubbish doctor and would never make a cardiologist'. Dr Orange was asked how she felt now; she said that she had been attending counselling and careers advice at the deanery and now felt less personally 'attacked' by the incident and was considering moving from hospital medicine to general practice. When asked if she could remember who else was present on the ward round who might have witnessed the incident Dr Orange said that the only other person she was sure was there was Dr Cyan, the FY2.

5.23. Professor Malachite was interviewed (Appendix 3 – Item V). When asked why he had not escalated the matter for over a month after Dr Orange's phone call and letter he explained that initially he had felt able to respect her views as she seemed content at that time that the matter was recorded. He then heard comments from other trainees that Dr Orange was becoming 'withdrawn and cynical' and told her that he was going to speak to Dr Maroon about it and she had not objected. He was also asked about his comment in his letter to Dr Maroon (Appendix 3 – Item G) about Dr Purple's attitude to trainees 'which is unsupportive and patronising'; his response, in his interview, was that he had no written evidence for this and that some might come from the GMC trainee feedback at the end of the year, but that this was 'general knowledge'.

5.24. Dr Maroon, Clinical Director, was interviewed (Appendix 3 – Item M). He said that he had discussed the incident, first with Dr Orange and then with Dr Purple. Dr Purple did

not deny the incident and apologised to Dr Maroon; Dr Maroon said that Dr Purple said he would also talk to Dr Orange. Neither of these meetings was documented and Dr Maroon said that in retrospect he would have done so. Ms Orchid followed this up with Dr Orange and asked her if Dr Purple had apologised and she said not (Appendix 3 – Item W).

5.25. In his first interview (Appendix 3 – Item L) Dr Purple, when asked about this incident, agreed that he had given Dr Orange feedback about her lack of skills in inserting pacemakers and lack of knowledge about their care, but said he did not think she should have been embarrassed or humiliated. He said ‘it’s my job to give them feedback – they need to have feedback or they will never improve’. He also said ‘the trainees nowadays are mostly no good – their training is awful’. In his second interview (Appendix 3 – Item X) Dr Purple was asked if he had spoken to Dr Orange and apologised to her; he said ‘She is working with Dr Maroon now so I don’t see her except in passing’.

5.26. Dr Cyan was interviewed (Appendix 3 – Item P) and confirmed that he was on the ward round with Dr Purple and Dr Orange on 22/11/12. He was asked if he remembered anything out of the ordinary about the ward round; he said that there was only one thing ‘Dr Orange suddenly went very quiet and then left the ward – she was gone for about ten minutes then she came back in. I was a bit worried because with the registrar not there I thought I would have to answer all of Dr Purple’s questions and he was a bit cranky that morning’. He was asked if he could be more specific and if he could remember what Dr Purple had said to Dr Orange before she left the ward. He said that he thought ‘he was asking her something about the patient – I was trying to make sure I had got all the test results in order for the next patient so I wasn’t listening closely’. He also said that ‘all of the trainees know you have to be perfect if you don’t want Dr Purple to shout at you’ and described him as ‘the most difficult consultant I have had to work with so far’.

5.27. As in the fact findings for TOR2, it is noted that Dr Purple has not attended training about the Policy HR01, The St Elsewhere’s Policy and Protocol for Dignity at Work and the Management of Harassment and Bullying (Appendix 3 – Item C).

5.28. Policy HR01 at paragraphs 4.2 and 4.3 there are descriptions of possible forms of harassment or bullying. In paragraph 4.2.1 harassment is described as ‘action, behaviour, comment or physical contact which is found to be objectionable by the recipient or which causes offence and can result in the recipient feeling threatened, humiliated patronised or isolated. It can also create an intimidating work environment’. Paragraph 4.2.2 says that harassment may be persistent or may occur on a single occasion’. Bullying is described in paragraph 4.3 as ‘offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient’.

TOR4. The circumstances relating to the two incidents in the catheter laboratory:

a. Patient no 12345 where vascular access was difficult to find

b. Patient no 67893 where there was difficulty with a pacemaker insertion

5.29. Dr Purple was asked about incident 12345 (Appendix 3 – Item H) and 67893 (Appendix 3 – Item I) in his interview (Appendix 3 – Item L) having been given the opportunity to review the case records and the incident forms. He agreed that both incidents occurred and that he had been grateful for Dr Maroon’s assistance and had let him complete both procedures. When asked if he had any explanation for these incidents he said ‘Well, I think both patients were rather difficult; the first was rather obese and the second had difficulty keeping still’ (Appendix 3 – Item L at para 5.7). He also said that ‘in retrospect I wasn’t feeling quite myself that week’. When asked if he had any specific health problems at around that time he said ‘certainly not’ (Appendix 3 – Item L at para 6.1). When it was put to him that two witnesses had mentioned that they thought he had a tremor he said ‘I do not have a tremor, and I will not discuss this or my health with you anymore. Can we concentrate on the issues and get through this; I’m a busy man and I have got a clinic to get to’ (Appendix 3 – Item L at para 6.5). Because a tremor or health issue might have been a contributory factor this concern was escalated to the Dr Mauve, the Medical Director on the same day. Dr Purple was then asked if he had needed to ask for help with procedures before, which he denied, and whether he got called to help others to which he replied ‘well, I seem to have to help out quite often, especially with these trainees these days...’ (Appendix 3 – Item L at para 10.2).

5.30. Dr Maroon was interviewed (Appendix 3 – Item Y) and confirmed his view of events as written on the incident forms 12345 and 67893 (Appendix 3 – Items H and I) which were both written on the day of the incidents. He was asked who had called him and said that it was the radiographer who had called him on both occasions, as the others were all ‘scrubbed’ (Appendix 3 – Item Y) and the radiographer wasn’t involved in the procedure at that time. He was not certain whether Dr Purple had asked for him to be called or if one of the other staff had been concerned and had asked someone to contact him. This was checked with Dr Purple who said that he remembered asking for help with the arterial access but he couldn’t remember how Dr Maroon came to be called to help with the pacemaker (Appendix 3 – Item X). Dr Maroon was asked if he ever had to call for help himself and whether he often got called to help others. He said that he had asked for assistance with a case several months previously and could remember helping one of his colleagues out earlier in the year. The Case Investigator checked the incident reports for the six months up to and including January 2013 and found no other incident reports relating to helping colleagues complete procedures in the catheter laboratory. When asked why he had completed incident reports on these

occasions Dr Maroon said 'Well, I was beginning to get worried about Dr Purple and I thought I should make sure that things were documented' (Appendix 3 – Item Y).

5.31. In her interview Dr Orange, who had been present at both incidents confirmed the basic facts on the incident reports (Appendix 3 – Item U). She said that on both occasions Dr Purple just seemed to get stuck and be unable to find the vessels – and that the procedures had been going on for some time. During the first case she said that she had offered to help but had been ignored, so she had instead concentrated on ensuring that the patient was okay by putting up a drip, checking the blood pressure and reassuring the patient. On the second occasion, where there was difficulty in inserting the pacemaker, she had herself gone and asked someone to call for assistance. When asked if she could remember any other times when Dr Purple had needed help she replied 'no – so I was very surprised when it happened twice in one week. Sometimes the other consultants will ask each other for help if they foresee difficulties but I haven't seen any of the others get into this situation where they just couldn't do the procedure' (Appendix 3 – Item U para 3.13)

5.32. Mrs Greenbank, the Manager of the Cardiovascular Department, who had been the senior cardiac technician previously, was asked what information was available about the consultants' performance in the catheter laboratory. She suggested the incident reporting system, which the Case Investigator told her had already been checked and showed no incidents reported from the catheter laboratory in the previous six months except 12345, 67893 and 1462. Mrs Greenbank said that they did keep records of all procedures which included total duration of procedure and radiation exposure during each procedure. She said that the radiographer had said that Dr Purple's exposure times seemed to be increasing. Mrs Greenbank agreed to provide a report by Consultant of these times over the previous year with Consultants identified by number. The report was received one week later (Appendix 3 – Item Z). This shows that until December 2012 the average duration of procedure and radiation exposure was very similar for all of the cardiology consultants. Since December 2012 Dr Purple's duration of procedure and radiation exposure per procedure have slowly risen, although Mrs Greenbank has told the case investigator that both are within the expected limits. Mrs Greenbank had also searched the operating log and found that every other consultant had a consultant colleague assisting once in the previous year, although the circumstances were not clear from that log.

5.33. The cardiac technician and the nurse who were assisting were the same at both incidents but both have now left the Trust and could not be contacted.

6. Conclusions

Conclusions are presented for each Term of Reference:

TOR1. The circumstances around the incident where a member of staff sustained a needle stick injury in the cardiac catheter laboratory on 15/11/12 (incident no 1462)

- 6.1. The evidence confirms that a needle stick injury occurred, injuring Staff Nurse Red, on 15/11/12. This is not contested by Dr Purple.
- 6.2. The evidence suggests that Dr Purple routinely works in contravention of the policy CP01 Disposing of sharps directly and in his own interview evidence he said 'I don't see the point of putting it in the bin myself'. Although it is not clear if Dr Purple knows what the policy says, it is clear that he has been asked to dispose of sharps properly on a number of occasions. He has not attended the Trust's training on sharps management. Dr Purple's actions had a causal relationship with the injury, which could have been avoided.

TOR2. The circumstances related to the complaints from a patient about shouting at staff on wards on 21/11/12

- 6.3. The investigation was unable to find any evidence to support the specific allegation that the 'new male nurse' was upset that was presented as hearsay in Patient Patterned's letter of 21/11/12 (Appendix 3 – Item E).
- 6.4. The more general allegations about shouting and bad behaviour were supported to some extent by the evidence from CN Brown and SN Red (Appendix 3 – Items N and O) but neither could recollect any specific issues from the day in question.
- 6.5. Evidence from the interviews with CN Brown, SN Red and Mrs Greenbank supports the allegation that Dr Purple may be loud and may have specific expectations of staff which could be construed as bullying and harassment but there is no recorded complaint about this previously.

TOR3. The circumstances related to the complaint from the trainee about Dr Purple stating that she will never make a cardiologist

- 6.6. Dr Purple in his meeting as reported by Dr Maroon and in his interview as part of this investigation (Appendix 3 – Item Y) does not deny that an incident took place, which he describes as 'feedback' to Dr Orange. Dr Cyan confirmed that something happened on that ward round to leave the room (Appendix 3 – Item P). Although Dr Orange could not

recall the exact words Dr Purple had used when she was interviewed (Appendix 3 – Item U) she had provided contemporaneous notes from the day of the incident in her letter to the Director of Medical Education (Appendix 3 – Item F).

6.7. On balance the evidence suggests that Dr Purple's behaviour may have amounted to harassment as described in Policy HR01 (Appendix 3 – Item C) at paragraphs 4.2 and 4.3. Dr Orange's letter clearly describes her as feeling 'humiliated' which is one of the descriptors in HR01 Para 4.2.1 in relation to harassment. Paragraph 4.2.2 of the policy also makes it clear that harassment can have occurred on a single occasion. The evidence with regard to bullying is less clear; it is described in paragraph 4.3 as 'offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient'. It is not clear that Dr Purple had intended that Dr Orange should feel humiliated as he indicated that he was 'giving feedback' which he regarded as part of his role (Appendix 3 – Item X).

TOR4. The circumstances relating to the two incidents in the catheter laboratory:

a. Patient no 12345 where vascular access was difficult to find

b. Patient no 67893 where there was difficulty with a pacemaker insertion

6.8. Dr Purple admits that both incidents happened and that he did need help to complete them.

6.9. From the available information it seems that Dr Purple has received help from a colleague twice in the last year and the other consultants have worked with a colleague once each. There is a suggestion, by the fact that Dr Purple's two incidents were closely related in time and that his procedure durations and radiation exposures have increased over the last few months, that he may be having some difficulty with procedures but there is no evidence that his performance in the catheter laboratory overall is outside what might be expected.

7. Appendices

1. Dr Mauve's letter dated 22/01/13 with initial terms of reference
2. Dr Mauve's letter dated 25/01/13 with amended terms of reference
3. Index of Evidence log and case bundle:
 - a. St Elsewhere's policy on disposing of sharps directly
 - b. NICE guidelines on disposing of sharps directly
 - c. St Elsewhere's policy on dignity at work
 - d. Incident report no 1462
 - e. Complaint letter from patient dated 21/11/12
 - f. Complaint from trainee dated 22/11/12
 - g. Complaint from Director of Medical Education dated 27/12/12
 - h. Incident notification: 12345 (Vascular access was difficult to find)
 - i. Incident notification: 67893 (Difficulty with pacemaker insertion)
 - j. Information from Dr Purple: Letter from Dr Cerise (ex-colleague) dated 23/01/13
 - k. St Elsewhere's Needle Stick Injury Report for FY11/12
 - l. Witness statement from Dr Purple's first interview
 - m. Witness statement from Dr Mauve's interview
 - n. Witness statement from Staff Nurse Red's interview
 - o. Witness statement from Charge Nurse Brown's interview
 - p. Witness statement from Dr Cyan's interview
 - q. Email confirming Dr Cyan's whereabouts
 - r. Witness statement from Mrs Greenbank's interview
 - s. Report from OH Manager regarding potential bullying and harassment by Dr Purple
 - t. Learning and Development report on bullying and harassment awareness raising
 - u. Witness statement from Dr Orange
 - v. Witness statement from Professor Malachite
 - w. Follow-up with Dr Orange regarding Dr Purple's apology statement
 - x. Witness statement from Dr Purple's second interview
 - y. Witness statement from Dr Maroon's interview
 - z. BLANK
 - aa. A&E letter regarding incident involving Staff Nurse Red
 - bb. OH letter regarding incident involving Staff Nurse Red
4. Example of HR form for interview witnesses
5. Report from Dr Neon's visit to cardiac catheter lab

Name of case investigator or investigating team:

Signature:

Date: