

THE EXPERT REVIEW OF RECORDS OF DECEASED PATIENTS OF DR WATT

MINUTES OF PHASE THREE STEERING GROUP - MEETING NO. 4

Held on Monday 01 December 2025 at 10.00 via MS Teams

Members:	Mrs Caroline Lee Professor Stuart Elborn Mr Brian O'Hagan Mr Ray Martin Mr Stewart Finn	RQIA Director / SRO / Chair RQIA Authority Board Ethical Advisor / PPI Lay Representative Director of MS Society / Vice Chair of NINCA
In Attendance:	Mrs Linda Rafferty Dr Leanne Morgan Mr David Silcock	Project Lead Clinical Lead Senior Communications Manager
Apologies:	Dr Seamus O'Reilly Dr Nazia Latif Mr Sean Green	RQIA Interim Responsible Officer RQIA Authority Board Project Support Officer

1.0 Welcome, apologies and declarations of interest

Mrs Lee welcomed members to the meeting and noted above apologies. No conflicts of interest declared.

Mrs Lee advised that she would like to pay particular thanks and respect to our colleague Malachy Finnegan who recently passed away. Malachy had been a key member of the group and made a helpful and significant contribution to this Review in his role as Senior Communications Manager. Members expressed their sincere regret at this very sad news.

2.0 Minutes of the previous meeting of the Steering Group held on 19/05/2025

Deferred until next meeting.

3.0 Updates on Progress

3.1 Phase 3 Group 1 (P3G1) x 18 cases

Dr Morgan provided the following update:

The Royal College of Physicians (RCP) expert review panel have completed the virtual review of the records. They provided RQIA with an overall report on the panel's findings, along with individual case summary reports, on 16 September 2025.

Fourteen of the families opted to engage with the Family Liaison Team (FLT) during October/November 2025 in order to discuss the expert panel's findings within individual case summary reports. A further three families decided they did not require a meeting with the FLT. The one remaining family, whom the FLT had difficulty contacting despite every reasonable effort being made, had recently requested and been provided with their deceased relative's case summary report. The FLT remain available to this family, should they decide to request a meeting to discuss the findings of the review panel.

During engagement sessions, seven of the families made comments with regard to the expert review panel's structured judgement review findings and gradings within case summary reports. The FLT committed to collating the comments for submitting to RCP in the new year, on behalf of the families.

It should be noted that in the event of RCP making changes to case summary reports following consideration of comments raised by families, the overall report may also require amendment.

The FLT continues to offer support to the P3G1 families. Work is in progress to update an information leaflet for sharing with the families. It will provide details of 'further options' for consideration e.g. the opportunity to avail of confidential counselling by Inspire, PCC advocacy, PSNI Operation Begrain, DoH Neurology Compensation process etc.

3.2 Phase 3 Group 2 (P3G2) x 7 cases

Mrs Rafferty provided the following update:

RQIA commenced the initiation of this further and final phase following confirmation of funding received from Department of Finance on 27 June 2025 and the Written Ministerial Statement to the Assembly on 09 July 2025.

Initiation included operational activity such as the development and approval of a Direct Award of Contract, formal commissioning of the RCP to undertake the review, and the completion of a Deed of Indemnity by the RCP and Department of Health (DoH).

The expert review panel have completed the virtual review of the records, with plans in place to hold full multi-disciplinary panel meetings over three days in December 2025, commencing on Monday 1st December. The purpose of the meetings is to consider the family testimonies submitted by RQIA on behalf of the families, and to agree the individual structured judgement review findings and gradings.

Arrangements are in place for individual families to meet, virtually, with representatives from the expert review team on 12th and 16th January 2026, facilitated and supported by the FLT. RCP have advised that, as with P3G1, the meetings will focus on listening to the accounts of the families, in order to appropriately reflect their voices in the review report; i.e. the review team do not intend to share the panel's findings during the virtual meetings with families.

The RCP will then develop a report on the findings of the review, along with individual case summary reports, for issue to RQIA.

Following receipt of the RCP report along with individual case summary reports (anticipated June 2026), the FLT will offer meetings with families to discuss the expert panel's findings. As with P3G1, there is the potential for families to raise comments regarding the findings of the panel, which may require submission to RCP for their consideration. It should be noted that should this occur, RCP may decide to make changes to individual case summary reports which could lead to changes to the overall report.

Note: The FLT held an Information and Support Event for the families of P3G2 in The Europa Hotel in September 2025, similar to that held for the families of P3G1 in February 2025. Key topics included:

- An overview of the process and progress to date
- What families can expect when they receive their RCP case summary report
- Looking after your wellbeing throughout the process, and support available

- The value of peer support, and
- Next steps

The event, although emotional for everyone in attendance, was very well received by the families.

4.0 Communications Update

4.1 Publication of Phase 3 Reports

The group considered and acknowledged the differences between Phase 2 and Phase 3 of the Review, in that the main focus of Phase 2 (report published November 2022) was to identify and make recommendations regarding systems learning, whilst Phase 3 focused on seeking answers for bereaved families regarding the care and treatment of their deceased relatives.

Members agreed unanimously that the families participating in Phase 3, interested members of the public, and others such as families who participated in Phase 2 will expect the RCP reports (Groups 1 and 2) to be published in their entirety, in common with the publication of the Phase 2 reports.

They also agreed that careful consideration should be given to the evaluation and closure of the programme in terms of issues such as the potential correlation of findings across the reports, the implementation of RCP recommendations and importantly, the ongoing legacy work across the HSC in Northern Ireland.

Item to be discussed in detail at next meeting.

5.0 Any Other Business

5.1 Steering Group Terms of Reference – updated September 2025

Members accepted minor amendments to the Terms of Reference (ToR) i.e. Mrs Caroline Lee replaces Mrs Lynn Long as RQIA Director/ SRO/ Chair of the Steering Group and Dr Seamus O'Reilly replaces Dr Ian Steele as a member of the group.

Action: Mrs Rafferty to liaise with the RQIA Communications team to arrange for the updated Terms of Reference to be published on the RQIA website.

5.2 Department of Health Update Bulletin October 2025

Members noted the October Update Bulletin.

Mrs Rafferty advised that, in accordance with a request from DoH, RQIA will circulate the bulletin to families engaged with Phase 3 of the Review for their information.

Mr O'Hagan made reference to the Independent Neurology Liaison Group (INLG), a co-production model of lived experience individuals directly harmed by the clinical failings that prompted the INI and now stood down. He advised that their generosity, rigour and pragmatism were exemplary and recommended the Final Involvement Report, produced by Tom Ward, Co-Chair of the group.

Mr O'Hagan also made reference to the INLG winning the 2025 'Individual Patient Experience' Picker Experience Network Awards (PENA). The PENA recognise outstanding excellence in patient experience; they celebrate projects, teams, individuals and initiatives that have made exceptional contributions to care, engagement, service delivery and wellbeing from the perspective of patients, carers and families, and staff.

5.3 PSNI Operation Begrain

Dr Morgan advised members that 166 people had made reports to Operation Begrain to date; 30 of the patients concerned are deceased, of which RQIA has been involved with 16. PSNI are reviewing the reports to determine potential criminal investigation such as gross negligence or manslaughter. They intend to submit a number of test cases to the Public Prosecution Service (PPS), to include at least 2 cases who were part of the Phase 3 expert review. It was noted that, as previously advised by PSNI, this investigation is expected to take years to complete.

5.4 Update on RQIA Legacy Commitments

Dr Morgan provided an overview of progress regarding RQIA's Legacy Commitments, which were made in response to learning arising from Phase 2 of the Expert Review.

Please refer to Appendix 1 for a comprehensive overview of the following:

- Being Human Framework
- e-learning Package

6.0 Date of next meeting, thank you and close

Members agreed to meet again mid-Spring 2026.

Mrs Lee thanked members for their valuable contribution and closed the meeting, wishing everyone a good Christmas.

RQIA Legacy Commitments

1 Being Human

'Being Human: A Framework for Safety Culture in HSC in Northern Ireland', led by RQIA Clinical lead Dr Leanne Morgan, launched on World Patient Safety Day at Mossley Mill on 17 September 2025 and is available on RQIA website: www.rqia.org.uk/BeingHuman

The framework represents a key output of RQIA's Legacy Commitment work. RQIA's legacy commitments were made in response to learning arising from Phase 2 Expert Review of Deceased Patients of Michael Watt, published in November 2022. The Framework was developed by co-production with involvement of HSC Stakeholders, including people with Lived Experience, and now referred to as Being Human Phase 1.

Aligned to DoH Quality Standards 2006, it aims to drive a culture within HSC that is safe and compassionate, just and open and continually learning and improving. It seeks to achieve this culture by shifting collective mind-sets, which fall under three domains, each accompanied by a series of expectation statements, setting out what 'good looks like for HSC'.

The Being Human Project Team are currently preparing for Phase 2: Moving from Concept to Reality, which will focus on the further work required to support implementation of the Framework. The aim is to utilise the Being Human Framework, to drive a culture that is Safe and Compassionate, Just and Open, and Continually Learning and Improving. There are 3 workstreams with the following objectives:

1. Pre-implementation: To support HSC Trust Boards to get ready for implementation of the Being Human Framework
2. Engagement : To promote engagement and involvement with the Being Human Framework across the HSC System including clinicians, patients and public
3. Assurance: To develop a robust assessment methodology to support assurance, in respect of safety culture

2 e-Learning Package

An e-learning programme developed by Dr Leanne Morgan, with support from the HSC Leadership Centre and a number of key stakeholders, 'Building a Safe and Compassionate Culture within HSC', was made available to all with access to the HSC e-learning platform in August 2025.

The Programme features the story of Stephen Sparkes, (as told by his mother Norma Sparkes, in short video clips), and the e-learning programme covers the following topics:

- Evidence-based practice
- Person-centred care
- Listening, Hearing and Acting
- Candour
- Creating Safe and Compassionate Cultures for Clinicians
- Governance

Access via this link: <https://learnhscni.portal-agyia.com/#/catalogue/landingpage/item/776cf24c-4e7c-4d42-8379-7d42ac49fbff/>

