THE EXPERT REVIEW OF RECORDS OF DECEASED PATIENTS OF DR WATT (*the Expert Review*)

Steering Group Terms of Reference for Phase Three of the Expert Review – Group 1 and Group 2

1.0 BACKGROUND AND CONTEXT TO THE EXPERT REVIEW

On 01 May 2018, Belfast Health and Social Care Trust (Belfast Trust) announced a recall of 2,500 patients in the context of concerns regarding the clinical practice of Dr Michael Watt, a consultant neurologist employed by the Belfast Trust.

On 02 May 2018, the Permanent Secretary of the Department of Health (DoH) issued a statement on the neurology patient recall. The statement included a direction for RQIA to undertake '*a Review of the governance arrangements of outpatient services in the Belfast Trust, with a particular focus on Neurology and other high-volume specialties*' (published February 2020) and 'a *Review of Governance Arrangements in Independent (Private) Hospitals in Northern Ireland*' (published June 2021).

The Permanent Secretary's statement also directed RQIA to "*commission a parallel piece of work to ensure that the records of all patients or former patients of Dr Watt who have died over the past ten years are subject to expert review*" (the Expert Review). Given the potential scale and complexity of the work, RQIA and the DoH agreed a phased approach to the Expert Review.

1.1 Phase 1

Significant work was involved in the completion of Phase 1, which was a preparatory phase, concluding in November 2020 with the formal adoption of operational protocols and a legal framework to ensure access to the relevant records and the appropriate infrastructure to enable robust, ethical and sensitive delivery of the review.

1.2 Phase 2

Phase 2 commenced in April 2021. This phase involved commissioning the Royal College of Physicians (RCP) to establish an Expert Panel of neurologist from outside of Northern Ireland. The Expert Review Panel reviewed the clinical records of 44 deceased patients (Group 1 and Group 2) and, where available, considered the testimony of families.

RQIA published an overarching report on Phase 2, which includes the RCP's Group 1 and Group 2 reports, in November 2022. Following Phase 2, the door for further families to approach RQIA regarding participation in a future phase of the review remained open.

1.3 Phase 3 – Group 1 and Group 2

Following a Written Ministerial Statement made to the NI Assembly by Health Minister Mike Nesbitt on 03 July 2024, RQIA commenced Phase 3 Group 1 of the Expert Review. This phase involves the clinical records of 18 deceased patients whose families, at that juncture and following engagement with RQIA's Family Liaison Team, had confirmed that they wished to proceed with an expert review of their deceased relatives' clinical records.

Minister Nesbitt's statement also stipulated that any further families of deceased patients of Dr Watt who wish to explore involvement in the Expert Review process should contact RQIA by no later than 31 December 2024. RQIA were approached by a further nine families prior to the Ministerial deadline. Following engagement with RQIA's Family Liaison Team, eight of the families confirmed that they wished to proceed with an expert review of their deceased relatives' clinical records.

Following a further Written Ministerial Statement made to the NI Assembly by Minister Nesbitt on 09 July 2025, RQIA commenced a further and final phase of the Expert Review, Phase 3 Group 2 x 8 cases.

1.4 Approach to Phase 3 of the Expert Review

In common with Phase 2, RQIA will commission the RCP to establish an Expert Panel of neurologists from outside of Northern Ireland to undertake an expert review of, firstly, the records of the deceased patients included in Phase 3 Group 1 and secondly, the records of the deceased patients included in Phase 3 Group 2.

The process will include the opportunity for families to provide their written testimony for consideration by the Expert Review Panel. In addition, families will also be offered the opportunity to meet with the Expert Review Panel. These meetings will be conducted virtually, facilitated and supported by RQIA's Family Liaison Team.

This approach will offer families an opportunity to have a two-way discussion with the Expert Panel and will enable the RCP to better reflect the experiences of families within individual case summary reports. The primary purpose being to provide the opportunity to impart answers, if possible, to the families in respect of the quality of care and treatment provided to their deceased relatives.

Furthermore, RQIA has enhanced its approach to engaging with families as part of Phase 3; this is in light of lessons learned from the findings of the Phase 2 report, the findings of an independent evaluation of the family experience of Phase 2, and individual family engagement exercises. Please refer to Appendix A for further details in this regard.

2.0 PURPOSE OF THE STEERING GROUP

The purpose of the Expert Review's Steering Group (the Steering Group) is to provide advice, guidance and oversight of the Project Team's work streams during the course of Phase 3 of the Expert Review. The Steering Group's alignment within the overall structure of Phase 3 of the Expert Review is illustrated in Appendix B.

The Project Team work streams include:

- Project management
- Engagement with bereaved families
- Preparation of clinical records for virtual review by Expert Review Panel
- Communications
- Legal Matters

Each of the above work streams will report to the Steering Group through the submission of highlight reports and/or verbal updates, as required. Specifically, the Steering Group will monitor the implementation and execution of Phase 3 of the Expert Review to assure it is undertaken in a sensitive, professional, ethical and transparent manner by providing and offering advice and guidance to the work streams on matters such as:

- Key decision points;
- Potential or actual issues or risks;
- The refinement, development and execution of the methodology of the review; and
- The review and sanction of key plans such as Family Engagement, Communications and Ethical Framework.

At the end of Phase 3, the Steering Group will reflect on any learning both from the process itself and any system learning identified. Following this reflection and / or evaluation, the Steering Group may wish to provide an opinion to the Authority on how any learning is taken forward and / or shared by RQIA for the purpose of improving future RQIA processes or HSC systems.

2.1 Membership

The Steering Group will be chaired by Mrs Caroline Lee, RQIA Interim Director of HSC Inspections, Reviews and Quality Improvement and Senior Responsible Officer for the Expert Review. Other members include:

- Dr Seamus O'Reilly, RQIA Interim Responsible Officer
- Professor Stuart Elborn CBE, RQIA Authority member
- Dr Nazia Latif, RQIA Authority member
- Mr Brian O'Hagan, Lay representative, Patient and Public Involvement and Ethical Advisor
- Mr Ray Martin, Lay representative with lived experience of involvement in Phase 2 of the Expert Review
- Mr Stewart Finn, Director of MS Society and Vice-Chair of the Northern Ireland Neurological Charities Alliance (NINCA)

Please refer to Appendix C for further information on each of the Steering Group members.

2.2 Additional members

The Steering Group has the provision to co-opt additional members as and when required throughout Phase 3 of the Expert Review, at the discretion of the group.

2.3 Attendees at Steering Group meetings

The Expert Review Project Lead, Clinical Lead and Communications Manager will not be members of the Steering Group but will attend Steering Group meetings as required in order to (a) provide members with updates on progress against key milestones, and (b) seek advice and guidance in the event of potential or actual issues or risks arising that may hinder the progress of the Expert Review.

Members of other RQIA work streams related to Phase 3 of the Expert Review will make themselves available to attend Steering Group meetings in order to provide relevant information or advice, as required.

2.4 Quorum

A quorum will be no less than 4 members of the Steering Group (of which there are 7 in total) to include a balance of representation from external representatives, RQIA Executive Management Team (EMT) and Authority members.

2.5 Frequency of meetings

The Steering Group will meet at least once every 3 months, or more often, as required. Meetings may be conducted virtually or in person.

3.0 LEGAL CONTEXT

The legal context under which RQIA operates is detailed in the Legal Framework for the Expert Review.

4.0 ACCOUNTABILITY AND REPORTING

Accountability for Phase 3 of the Expert Review and each of its key work streams will be retained by the RQIA. The Senior Responsible Officer will report to the RQIA Chief Executive and will be required to regularly update RQIA's Authority members and will provide updates to key stakeholders as required, on behalf of RQIA, on matters relating to the Expert Review.

5.0 OTHER MATTERS

5.1 Agendas

An agenda for the meetings, save in exceptional circumstances, will be circulated to members at least five working days before each meeting and password protected supporting papers, wherever possible, will accompany the agenda.

5.2 Conflicts of Interest

Members of the Group will be asked to declare any potential conflict of interest at each Group meeting, or earlier if they deem appropriate.

5.3 Formal minutes of meetings

A member of the Expert Review Project Team will attend the Steering Group meetings to formally minute the meeting. The minutes will be approved by the Group and published on the RQIA website.

5.4 Information Sharing

Members of the Steering Group will direct all requests for information about the work of the Review to the Chair of the group, unless this information is already publicly available. Members will be kept informed of any issues raised by the public or their representatives in relation to Phase 3 of the Expert Review, or consideration of approach to next steps, during group meetings.

5.5 Terms of Reference

These Terms of Reference relate specifically to Phase 3, Groups 1 and 2 of the Expert Review, and may be reviewed and further developed at key milestones as the review progresses.

1.0 ENHANCED APPROACH TO FAMILY ENGAGEMENT

RQIA has enhanced its approach to engaging with families as part of Phase 3; this is in light of lessons learned from the findings of the Phase Two report, the findings of an independent evaluation of the family experience of Phase Two, and engagement with families who had approached RQIA wishing to explore participating in an Expert Review of their deceased relatives' clinical records.

1.1 Phase Two Report

The Expert Review Panel examined cases firstly without family stories and secondly with the family stories. They looked at diagnosis, prescribing, treatment, follow-up, communication, multi-disciplinary team (MDT) working, potential harm and cause of death. The panel found:

- Poor practice including a lack of proper clinical investigation;
- Inaccurate diagnosis;
- Poor prescribing practices;
- Poor record keeping;
- Lack of openness and effective communication;
- Inappropriate treatment;
- The risks of clinicians working in isolation.

1.2 Independent Evaluation

Following Phase Two, RQIA commissioned an independent evaluation[1] of the experience of family members involved in the review. All the families involved in the review were offered the opportunity to participate in this evaluation. A total of 17 individuals or families agreed to participate.

The findings of the evaluation raised important ethical considerations around potential adverse impact on families by the clinical records review process due to protracted timescales, re-traumatisation, and the final reports not meeting family expectations.

1.3 Engagement Exercise with Families

RQIA undertook engagement exercises with families who had contacted RQIA to express an interest in participating in a further phase of the review up to the Ministerial deadline of 31 December 2024. The purpose of this engagement was to ascertain expectations and to provide open and honest information about the Expert Review process, its benefits and limitations, and alternative options available.

[1] A Rapid and Structured Evaluation of the Experience of Family Members Involved in the Expert Review of Records of Deceased Patients (Neurology) – November 2022

2.0 FAMILY ENGAGEMENT

Lessons learned from all of the above has led RQIA to make improvements to their arrangements for engaging with the families who are participating in Phase 3 of the Expert Review. We are mindful of the importance of managing family expectations and committed to ensuring that families are fully informed about the process, its benefits, its limitations, and its potential to cause distress.

2.1 Family Liaison Team

Phase 3 families are supported by the same Family Liaison Team (FLT) model as that of Phase 2, in accordance with the recommendations of the independent evaluation. The FLT includes a clinical psychologist, and families may also access Lena by Inspire Wellbeing independent counselling and Patient and Client Council (PCC) advocacy support.

From the outset families are asked to advise of their preferred method for engaging with the FLT, i.e.

- In-person
- Virtually
- Via phone and email or post
- Via email and/or post only

Individual family members preferred engagement methodology choices can and do change as the clinical record review process progresses.

2.2 Information materials

A suite of information materials including Family Information Leaflets, an Easy Read Guide, a Coping with Grief Leaflet, and a video of a family member with Lived Experience of the Phase 2 process are made available to families.

In addition, detailed information regarding the following key points is provided both verbally and/or in writing, depending on each individual family members preferred method of engagement.

2.3 The limitations of a clinical record review

- An expert review is a clinical review of the medical notes and records only. The review cannot by itself deliver justice, hold parties to account and/or impose sanctions and/or penalties. RQIA does not have the statutory powers to deliver these outcomes;

- There is the possibility that the expert review of the clinical records may not align with family experience of their relative's care and treatment. The outcome of the clinical record review does not affect a family's right to pursue legal action;

- An expert review of clinical records depends on the quality of the documentation within the records. It is possible that information in relation to a person's care may not be adequately or accurately documented within their clinical records. This can

limit the amount of useful information available to the expert panel in order for them to make their assessment. For these reasons, it is possible that some families may not get answers to all their questions. It is also possible that the findings of the expert panel may conflict with the experience of family members. This may mean that families do not get the closure that they had hoped for and may also mean that the record review itself, including the final report, for some can become a distressing experience.

- It can take a long time for an expert review of clinical records to be completed. This is largely due to the RCP's robust review processes; the time it takes to write up the overall report and individual case summary reports; quality assurance of the reports and checking for accuracy. For these reasons the estimated date of when a report will be available can change. Uncertainly and changing timescales in relation to when family members will receive their final report can be difficult for some families to deal with. From beginning the process, to receiving the Expert Panel's final report, can take 12 – 18 months, and it is possible that it could take even longer.

2.4 Other options available to families:

- Neurology Compensation Claims
- Submitting a complaint to the healthcare provider
- Police Service of Northern Ireland (PSNI)
- Coroner's Service Northern Ireland (CSNI)

2.5 Provision of ongoing support:

- Families can contact our dedicated Family Liaison Team by ringing Freephone Telephone Number 0800 052 0012, or by sending an email to expert.review@rqia.org.uk

- All families can access Lena by Inspire Wellbeing Counselling Service for counselling support through our Family Liaison Team. This support is available to family members, free of charge.

- RQIA can also signpost families to the Patient and Client Council regarding advocacy support.

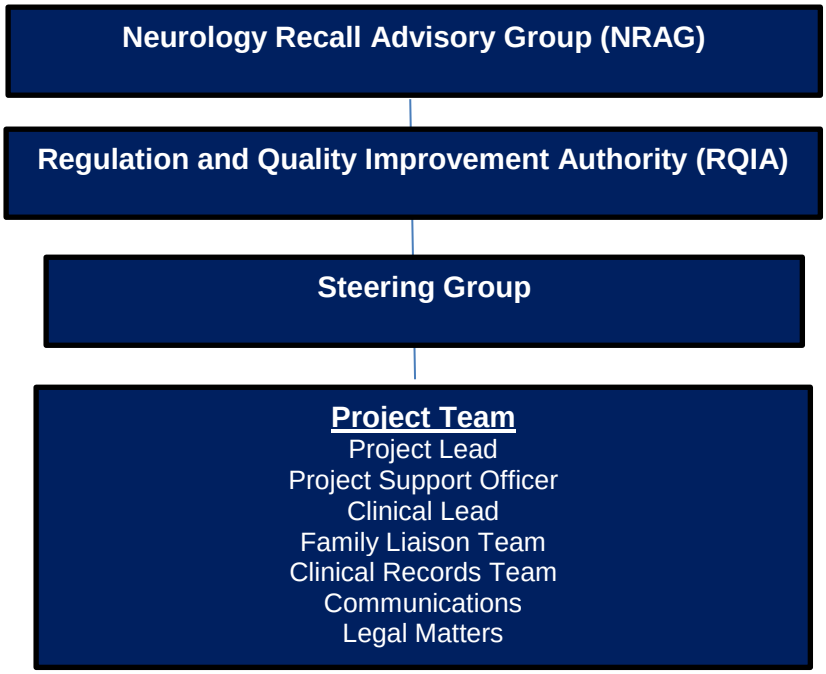
- There is a range of information available on RQIA's website www.rqia.org.uk including written information on the Review and information on Coping with Grief.

2.6 Other organisations that provide support:

- Lifeline – 24-hour support for those in distress or despair
- Samaritans
- Cruse Bereavement Care

APPENDIX B

PROJECT STRUCTURE



MEMBERSHIP

Neurological Recall Advisory Group

- Department of Health (DoH)
- Strategic Planning and Performance Group (SPPG)
- Public Health Agency (PHA)
- Regulation & Quality Improvement Authority (RQIA)

Steering Group

- Mrs Caroline Lee, RQIA Interim Director of Inspections, Reviews and Quality Improvement and Senior Responsible Officer for the Expert Review
- Dr Seamus O'Reilly, RQIA Interim Responsible Officer
- Professor Stuart Elborn CBE, RQIA Authority Member
- Dr Nazia Latif, RQIA Authority Member
- Mr Brian O'Hagan, Lay representative, Patient and Public Involvement and Ethical Advisor
- Mr Ray Martin, Lay representative with experience of involvement in Phase Two of the Expert Review
- Mr Stewart Finn, Director of MS Society and Vice-Chair of the Northern Ireland Neurological Charities Alliance (NINCA)

Project Team – includes representatives from each of the working groups

- Mrs Linda Rafferty, Project Lead
- Mr Sean Green, Project Support Officer
- Dr Leanne Morgan, Clinical Lead
- Mr David Silcock, Communications Manager
- Professor Nichola Rooney, Consultant Clinical Psychologist / Professional Advisor to the Family Liaison Team
- Mr Sean McDermott, Consultant Solicitor, Directorate of Legal Services (DLS)

Family Liaison Team

- Dr Leanne Morgan, Clinical Lead
- Professor Nichola Rooney, Consultant Clinical Psychologist
- Mrs Linda Rafferty, Project Lead
- Mr Sean Green, Project Support Officer

Clinical Records Team

- Mr Sean Green, Project Support Officer
- 2 x Digitisation Officers (temporary agency)

Communications

- Mr David Silcock, Communications Manager
- Mrs Linda Rafferty, Project Lead
- Mr Sean Green, Project Support Officer

Legal Matters

- Mr Sean McDermott, Consultant Solicitor, Directorate of Legal Services (DLS)

APPENDIX C

STEERING GROUP MEMBERS

Mrs Caroline Lee – Chair of the Steering Group

Caroline Lee, MBE is Interim Director HSC Inspections, Reviews and QI with RQIA, a position she has held since July 2025.

Caroline is a registrant with the Nursing and Midwifery Council (NMC) for 38 years and has held a range of senior posts in the HSC. Caroline was most recently Head of the Clinical Education Centre (CEC) (2017-2021) and prior to that Deputy Chief Nursing Officer for Northern Ireland (2013-2017). Caroline led the Covid response in CEC, extending its offering of programmes to the independent sector and to all health professionals, these initiatives led to an award of an MBE. During her time in CEC Caroline extended its range of programmes, its facilities and overseen the development of a Simulation Suite to support the delivery of new programmes such as Human Factors and Root Cause Analysis. Caroline was part of the steering committee for Delivering Care: Safe Staffing, playing a key role in its policy development and its implementation. Caroline was also a member of the Nursing and Midwifery Task Group providing expertise on workforce and education.

Caroline has specific training in undertaking and chairing Serious Adverse Incident (SAI) Reviews as well as Root Cause Analysis (RCA) Reviews. Caroline is a Florence Nightingale Scholar, has a Master's degree in Health Service Management and a Post Graduate Certificate in Workforce Planning and her clinical experience was in general and renal medicine.

Dr Seamus O'Reilly, RQIA Interim Responsible Officer

Dr Seamus O'Reilly, MB, Bch, BAO, DRCOG, MRCGP, MRCPI, FRCS (A&E), FFAEM, LLM, was a consultant in Emergency Medicine and a Divisional Medical Director at the Southern Health and Social Care Trust from 1999 until 2016. Subsequently, he assumed the position of Medical Director at the Northern Health and Social Care Trust (NHSCT) until his retirement in August 2022.

He completed a master's in medical law (LLM) in March 2016 with his dissertation on the statutory duty of Candour.

In addition to his extensive experience in all areas of healthcare on a local, regional, and national scale, he has served as a member or provided advice to a number of group including the NICON professional support committee, the Nosocomial COVID-19 deaths review group, the DHCNI portfolio board, the Advance Care Planning Group for Adults, the NIGEMS Project Board, the Responsible Officer Reference Group (GMC) and the iSimpathy project board.

He was also Chair of the Encompass Care Executive, a member of the Encompass programme board and a member of the IHRD Duty of Candour/Being Open workstream.

Having a keen interest in clinical leadership, he developed the CONNECT leadership programme for the NHSCT, which is accredited by the Faculty of Medical Leadership and Management (FMLM).

He is currently working with the Department of Health (DoH) on the redesign of the current Serious Adverse Incidents (SAI) process and is interim Responsible Officer for the Regualtion and Quality Improvement Authority (RQIA).

Professor Stuart Elborn CBE – Member of RQIA Authority

Professor Elborn is Professor of Medicine, and Provost and Deputy Vice-Chancellor (interim) at Queen's University. He is responsible for planning, governance and academic performance across the University. His research is focused on improving outcomes in people with chronic lung disease particularly cystic fibrosis and bronchiectasis.

Professor Elborn was appointed to RQIA's Interim Authority on 30 October 2020 and as a Member of the Authority from 1 February 2023 for a four-year term. He chairs the Authority's Business, Appointments and Remuneration Committee (BARC).

Dr Nazia Latif – Member of RQIA Authority

Dr Latif has extensive experience of working on human rights and equality issues in Northern Ireland and internationally. She worked for the Northern Ireland Human Rights Commission for 13 years where she led systemic investigations, including "In Defence of Dignity", an investigation into the human rights of older people in nursing homes. Dr Latif currently runs Right Practice, which specialises in human rights and equality obligations. She is a member of the Northern Ireland Committee of the Joseph Rowntree Charitable Trust and is an Independent Assessor for Diversity Mark. Dr Latif was appointed as a Member of the Authority on 1 February 2023 for a four-year term.

Mr Brian O'Hagan – Lay representative, Patient and Public Involvement and Ethical Advisor

Mr O'Hagan's professional background is in the information and technology sector, but for many years, he has been involved in healthcare from a service user and carer perspective. He is a campaigner for the rights of service users and carers to be at the heart of rebuilding Health and Social Care services, and for over a decade he has been involved in the development of the Personal and Public Involvement (PPI) and currently is vice chair of the Regional HSC PPI Forum.

Over the years, Mr O'Hagan has participated in various Departmental health groups, including:

- Health Minister's Transformation Advisory Board
- Regional HSC Clinical Ethics Forum
- Co-production Guidance Working Group
- NI Dementia Strategy Steering Group
- Dementia Risk Assessment Tools Development Group

He is also a member of the Implementation Programme Management Group, which was set up in response to the Inquiry into Hyponatraemia-Related Deaths (IHRD); within this programme he sits on the IHRD Duty of Candour Work Stream and Chairs the Service User and Carer Liaison Group.

Mr O'Hagan has previously participated in RQIA reviews as a lay reviewer, including the Carer's Support and Needs Assessment Tool and more recently the RQIA Review of the Serious Adverse Incidents Process and as a member of the Steering Group for Phase Two of the Expert Review.

Mr Ray Martin – Lay representative with experience of involvement in Phase Two of the Expert Review

Mr Martin is a retired civil servant. His mother died in April 2016 while in the care of Dr Michael Watt. The case was subject to Expert Review during Phase Two of the examination of records of deceased patients of Dr Watt. As an interested family member, he participated in all aspects of the process, including the post-Review evaluation of the experience of relatives of the deceased.

Coincidentally, Mr Martin's previous career was in the former Department of Health and Social Care. His experience includes the organisational and governance structures within health and social care during the period 1991 to 2014. He has been involved in the development of policy and practice in areas such as clinical and social care governance and controls assurance. On foot of the Health and Social Care Reform Act 2009 he was directly involved in developing the statutory HSC Framework Document, which defines the roles and responsibilities of bodies within the health and social care family.

Mr Martin's practical experience of Phase Two, coupled with his career experience, will allow him to make a positive contribution to the Steering Group oversight of Phase 3 of the Expert Review.

Mr Stewart Finn, Director of MS Society and Vice-Chair of the Northern Ireland Neurological Charities Alliance (NINCA)

Mr Finn has a background in politics, having been part of the Northern Ireland Assembly in the decade that followed the Good Friday Agreement. He joined the MS Society seven years ago as Policy, Press and Campaigns Manager before becoming the Director for Northern Ireland in 2024.

His passion lies in true co-production, working closely with people living with MS to shape and improve the public policy, services and support that impacts their lives. He is deeply committed to the development of the MS network of local groups and volunteers, enhancing our community and the support they provide to people living with MS in Northern Ireland.

Mr Finn's career experience to date, which includes involvement with patients affected by the Neurological recall since 2018, will allow him to make a positive contribution to the Steering Group oversight of Phase 33 of the Expert Review.