The Regulation and Quality Improvement Authority

Final Report on the Expert Review of Records of Deceased Patients (Neurology)

September 2026

Foreword

This final Report of the Review of Records of Deceased Patients of Michael Watt brings together the findings, recommendations and legacy actions to date of all three phases of the Review undertaken by RQIA. The Report's findings from the record reviews make sobering reading; but there is progress in the subsequent action across the system to implement recommendations.

Overall, and most importantly, the Review as a whole has given powerful evidence of the devastating impact of poor clinical practice, for patients and for their families. This demonstrates the need for patient safety, and so the quality of care, to be the central focus of professional and management attention in delivering health and social care services.

The last phase of this unique Review process has reinforced recognition of the consequences of poor care on people's lives. It has provided answers for families where possible. It will also continue to act, as its precursors have done, as a powerful and enduring driver for actions that lead to positive change, and prevent recurrence of the cultures and behaviours contributing to failures of care.

The outcome of the Review of the first group of records was published in November 2022. This involved records of 44 deceased patients, across two cohorts. It identified individual clinical failings and pointed also to wider systemic issues.

The Review concluded that a combination of poor diagnostic practice, inadequate communication, isolated clinical decision-making, weak multidisciplinary oversight, and lack of a patient-centred approach resulted in care that frequently fell below expected standards. In a significant number of cases, this was the cause of harm through delayed or mis-diagnosis, inappropriate treatment, medication side effects, missed opportunities for support, and failures in communication.

Family concerns were validated. Of the concerns reviewed, the majority were either fully or partially upheld by the independent expert panel. This initial Review Report pointed to the scale and impact of the failings, and identified the issues to be addressed.

It then became apparent that further families also had questions, and wished the records of their deceased loved one to be reviewed, to seek answers. In July 2024 Minister Mike Nesbitt MLA invited any further families to come forward to RQIA by the end of December 2024, if they wished for the records of their loved one to be reviewed. A further 25 families did so.

These records were reviewed, in two groups of 18 and 7 respectively, with the intent of answering the families' questions, if possible. The findings from the Review of these records concurred with those from the first Review Report.

The quality of care was frequently below the standard expected, with concerns identified across diagnosis, treatment, prescribing practices, communication, record keeping, a lack of coordinated multidisciplinary involvement and poor communication with patients and families.

These findings reinforced the earlier Review finding that patients were adversely affected by an isolated style of practice with insufficient challenge, oversight, and teamwork.

RQIA wishes to pay tribute to the contribution that all the families involved have made to this Review. Family testimonies provided powerful and insightful evidence; and without their contributions the Review would have lacked essential elements of understanding and experience.

Clinical and administrative documentation and records alone do not, and cannot, provide adequate evidence to assess patient safety fully. The need for, and value of, personal, experiential "eye witness" evidence has been formally recorded in the recent Report of the Muckamore Abbey Hospital Public Inquiry.

The RQIA set out to undertake this Review at the request of the Minister and Department of Health. RQIA was determined to do so robustly and sensitively; and to ensure that the Review had a continuing and constructive impact for future patients, families, clinicians, managers, leaders, regulators and others.

RQIA has made commitments to ensure that there is a continuing positive legacy from the Review, including the co-development of a Patient Safety Culture Framework for Health and Social Care in Northern Ireland. That has resulted in 'Being Human', a co-produced, HSC safety culture assessment framework, now being tested and used across Health and Social Care organisations.

Following the publication of the two latest Public Inquiry Reports, former Minister Mike Nesbitt MLA publicly set patient safety as the overriding priority for the whole Health and Social Care system.

He clearly identified that this requires an open, listening and enquiring culture; where people, patients, families and staff know that they can speak up, and that concerns will be heard and addressed effectively. He charged the leadership of the Health and Social Care organisations with bringing this about.

I have no hesitation in saying that, in my view, this strong and clear focus is due to the courage and iron determination of patients and families to seek the truth and to insist on change, so that others do not suffer as they have suffered.

However, RQIA recognises that such family involvement and participation come at personal cost. How painful to share the personal experience of suffering the loss of a loved one; and how brave and public spirited.

RQIA can only thank all the families involved and hope that participation has given answers to some of the questions, and that this Review, and the actions taken as a result, are a positive legacy.

The experience and voices of patients and families must stay to the fore, and continue to drive the changes that must be made across the whole system. RQIA is committed to that journey; and to continuing to work with patients and families to secure and improve the quality and safety of health and social care in Northern Ireland.

Christine Collins MBE,
Chair

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1. INTRODUCTION AND CONTEXT

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

On 02 May 2018, the Permanent Secretary of the Department of Health, in announcing an RQIA review of the governance arrangements of outpatient services in the Belfast Trust, also announced that RQIA would commission an expert review of the records of all patients of Michael Watt who had died in the preceding ten years (2008–2018).

On 10 May 2018 the DoH announced the establishment of a separate Independent Inquiry (converted to a Public Inquiry in December 2020) under the Chairmanship of Brett Lockhart QC (since published on 21 June 2022). Separate to this Public Inquiry, and underpinning the Permanent Secretary's 02 May 2018 announcement, the Chief Medical Officer, Professor Sir Michael McBride issued a formal direction to the RQIA on 10 May 2018 to ***"commission an expert review of the records of all patients (current and former) of Dr Watt who have died over the last ten years"***.

Given the potential size and complexity of the Expert Review, RQIA subsequently agreed with the DoH that it would be taken forward on a phased approach.

Phase 1

Phase 1 pertained to a period of significant planning and preparation, including the development of a Legal Framework, operational protocols and appropriate arrangements to enable progression to the next phase of the Expert Review, whilst ensuring a robust, ethical and sensitive approach, and the negotiation of a contract with the Royal College of Physicians (RCP).

Phase 2

Phase 2 commenced in August 2021. RQIA commissioned the RCP to undertake an Expert Review of 44 cases using structured judgement methodology to examine the clinical records and, where available, to consider the testimony of families. The overall report on Phase 2 of the Expert Review was published in November 2022 and can be accessed at https://www.rqia.org.uk/reviews/deceased-patients-review/

This report highlighted significant learning, which RQIA has committed to utilising in order to support improvement across the Health and Social Care (HSC) system through the delivery of 'Legacy Commitments' (see later in this report).

Phase 3

Phase 3 involved commissioning the RCP to undertake an Expert Review of a further 25 cases using structured judgement methodology to examine the clinical records of two further groups of deceased patients, and to consider the accompanying family statements provided by all 25 families.

The review of Phase 3 Group 1 commenced following the announcement of a written Ministerial statement on 03 July 2024, on the next steps and future approach to the Expert Review.

This group consisted of 18 deceased patients whose families had approached RQIA, and, following a period of engagement with the Family Liaison Team, had confirmed their wish to have their loved ones' clinical records reviewed. Whilst Phase 2 focused on maximising learning, the primary purpose of Phase 3, in accordance with the Minister's statement on 03 July 2024, focused on providing the opportunity to impart answers, if possible, to the bereaved families in respect of the quality of care and treatment provided to their deceased relatives.

The Minister's statement on 03 July 2024 included the provision of a six-month period for any additional families interested in having their deceased family member's clinical records reviewed, to contact the RQIA to explore involvement in the process by no later than 31 December 2024.

The RCP final report of Phase 3 Group 1 was received by RQIA in September 2025, whilst the review of Phase 3 Group 2 was in progress.

The review of a final phase, referred to as Phase 3 Group 2, commenced following a further written Ministerial statement on 09 July 2025, which directed RQIA to undertake a review of the clinical records of deceased patients whose families had contacted RQIA following commencement of the review of Phase 3 Group 1, and prior to the Ministerial deadline of 31 December 2024.

This group consisted of eight deceased patients whose families had, following a period of engagement with the Family Liaison Team, confirmed their wish to have their loved ones' clinical records reviewed. The number of cases reduced to seven when it was discovered that one of the deceased patients had never been under the care of Michael Watt.

RQIA received the RCP final report of Phase 3 Group 2 on 28 May 2026. This brought RQIA's work on reviewing the clinical records of deceased patients of Michael Watt to a close, having completed the final phase of the review as per the Minister for Health's written statement on 09 July 2025.

This report sets out the findings of the Phase 3 Group 1 and 2, and a high level overview of the findings from the earlier Phase 2. The findings are clearly very similar. This report also refers to the recommendations that the RCP made from each of the Reviews and provides an update on the actions taken to date.

The Legacy commitments made by RQIA at the publication of the Phase 2 Report are followed through, giving particular attention to the development of the 'Being Human' Framework, a HSC whole-system approach to Safety Culture. The origins of this lie in the review of the Deceased Patient Records.

2. THE EXPERT REVIEW: METHODOLOGY, BENEFITS AND LIMITATIONS OF A CLINICAL RECORD REVIEW

Structure and Oversight

RQIA established a robust project management structure to ensure effective delivery of all Phases of the Expert Review of Records of Deceased Patients. As Phase 3 commenced, a revised Ethical Framework, originally developed by an Ethical Advisory Group in partnership with the project team, provided principles to guide decision-making and ensure that the Expert Review was conducted in an open, transparent, sensitive and fair way.

A personalised programme of family engagement was undertaken by a dedicated Family Liaison Team established by RQIA. Team members included RQIA's Clinical Lead, a consultant clinical psychologist, and the project lead supported by a family liaison support officer.

The team ensured that the families who had approached RQIA with concerns regarding their loved ones' care and treatment, were advised of the potential benefits, limitations and potential protracted timescales of a clinical record review, to enable them to make an informed decision with regard to participating in the Expert Review. Arrangements regarding contact with individual families were agreed from the outset, to ensure they received regular updates on progress of the Expert Review, in a preferred method of their choosing.

The team liaised closely with the families who participated in the review of their loved ones' clinical records throughout each phase of the Expert Review. This included supporting families to provide written statements for the expert panel's consideration, and holding in-person meetings with individual families to discuss the panel's findings within individual case summary reports. Individual case summary reports are confidential and are therefore not published.

Access to Inspire Wellbeing counselling services was provided to those families who opted to request a referral.

A suite of information materials, along with a dedicated email address and Freephone telephone number monitored by the Family Liaison Team, were made available to families.

Royal College of Physicians (RCP)

RQIA commissioned the RCP to undertake an Expert Review of the clinical records, Phase 2 with a total of 44 records of deceased patients and Phase 3, a total of 25 deceased patients records (across both groups of Phase 3 - Group 1 and Group 2), to include consideration of family statements, and to produce an overarching report for each group along with individual case summaries for each patient.

An expert panel of three specialist clinical reviewers, from outside of Northern Ireland, was established and a review team convened.

The process for the Phase 3 reviews largely mirrored the previous Phase 2 review approach, with RCP adding an additional element of affording families the opportunity to meet directly, using videoconferencing software, with representatives from the review team, to share their experiences in their own words. This was offered in the Phase 3 review and 22 of the 25 families accepted the offer to meet with the review team, supported and facilitated by the RQIA Family Liaison Team.

The Family Liaison Team received very positive feedback from the families, who expressed their appreciation for the opportunity to have a two-way conversation with the RCP representatives and to speak about the person behind the patient records. The review team conveyed to RQIA that they regarded it as both a privilege and a challenge to have undertaken this work.

Benefits

An Expert Review of clinical records by an expert panel uses a reliable, well-validated structured judgement methodology, making an independent assessment of the care and treatment as documented in the clinical records.

This clinical assessment provides judgements of the quality of care and treatment in accordance with the standards at the time that the treatment was provided. It can also provide a judgement on whether the diagnosis was secure, whether the treatment and follow-up was appropriate and whether there was potential for harm.

A review of clinical records can provide families with answers to questions if the documentation contained within the records is of a standard that enables the expert panel to draw reliable conclusions from the information available.

The expert panel may also identify shortcomings in the care and treatment of individual patients and, in some cases, make recommendations. Recommendations may include changes to the death certificate and/or referral of the case to the Coroner for consideration of an inquest.

By reviewing a group of cases, the expert panel may also identify learning for the health and social care system and make recommendations to improve the quality and safety of healthcare services and systems.

Limitations

An Expert Review is a clinical review of the clinical records only. The review cannot by itself deliver justice for those affected, it cannot hold parties to account and/or impose sanctions and/or penalties.

There is also the possibility that an Expert Review of clinical records may not align with a family's experience of their loved one's care and treatment. 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.

In this review of records over both phases, the review of the clinical records has been significantly added to by the testimonies of families. Together, the evidence collated, and the overall judgements reached, are powerful and compelling.

3. REVIEW FINDINGS AND IMPACT FOR PATIENTS AND FAMILIES

The RCP review of records of deceased patients was undertaken across both phases of the review programme. Phase 2 involved the review of 44 cases, while Phase 3 comprised two groups of records (Phase 3 Group 1 and Group 2) making up a total of 25 records. Phase 3 RCP, completed on 28 May 2026, identified consistent and recurring concerns across both phases relating to diagnostic practice, clinical decision-making, communication, multidisciplinary working and patient-centred care.

While the two phases differed in composition of the cases reviewed, the findings were very similar. The findings of each of the two Phases are set out below and then a conclusion summarises the findings overall and the impact on patient care and treatment, and the impact for families.

The following sets out the findings from each of the Phases as taken from the collated reports prepared by the RCP.

3.1 A Summary of Findings from the Phase 2 Review (November 2022)

The first RCP report on the review of Deceased Patient Records (known as Phase 2) involved two groups of records making up a total of 44 deceased patient records. The review identified significant failures in the care and treatment of patients, and significant concerns over a wide range of matters of clinical practice including clinical decision-making, diagnostic approach, communications with other clinicians, and communication with patients and families. A high-level summary of the findings from the Phase 2 review are set out below as much more detail is available in the full report. The report from Phase 2 was published in full in November 2022 and is available at https://www.rqia.org.uk/reviews/deceased-patients-review/

Overall Quality of Care

The findings from both groups of records indicated a pattern of care that frequently fell below expected professional standards. In Cohort 1, none of the 29 cases were considered to represent good practice, with 14 cases graded as unsatisfactory and the remainder requiring improvement. In Cohort 2, despite patients not generally being associated with prior concerns or complaints, more than half of cases (53%) were also graded unsatisfactory, with only two cases assessed as good practice.

The consistency of these findings across both groups was significant. The RCP concluded that the quality of neurology care provided was below the standard expected in the majority of cases reviewed and that the concerns identified could not be regarded as isolated incidents.

Diagnostic Practice and Clinical Decision-Making

The most prominent theme across both cohorts was concern regarding diagnostic accuracy and clinical reasoning.

The review found that diagnoses were frequently made without sufficient clinical evidence, appropriate investigations or consideration of alternative explanations for symptoms.

In Cohort 1, 45% of diagnoses were considered insecure, while in Cohort 2 the figure was 40%.

The review identified repeated concerns regarding the diagnosis of epilepsy. Across both cohorts, patients were often diagnosed with seizures or epilepsy without adequate supporting evidence, such as EEGs, MRI scans, telemetry or detailed witness accounts. Alternative causes of blackouts, falls or altered consciousness were frequently not explored.

Similarly, the diagnosis and treatment of Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) emerged as a recurring concern. In several cases, patients received extensive treatment, including intravenous immunoglobulin therapy, despite the RCP finding that accepted diagnostic criteria for CIDP had not been met. The review questioned both the accuracy of these diagnoses and the appropriateness of subsequent treatment.

Clinical decision-making was frequently assessed as poor. The reviewers found evidence of premature diagnostic conclusions, overreliance on medication, failure to reassess diagnoses when patients failed to improve, and inadequate use of specialist opinion or multidisciplinary review when managing complex neurological conditions.

Potential for Patient Harm

Across both cohorts, the RCP identified a substantial number of cases where care may have resulted in patient harm. Potential harm was identified in 45% of Cohort 1 cases and 60% of Cohort 2 cases. Harm was considered broadly and extended beyond physical injury to include psychological distress, prolonged uncertainty, unnecessary treatment and lost opportunities for supportive care. The review highlighted concerns regarding:

- exposure to unnecessary medications and their side effects;
- inappropriate use of steroids, anti-epileptic drugs and immunoglobulin therapy;
- delays in establishing an accurate diagnosis;
- failure to provide appropriate supportive or palliative care;
- missed opportunities to refer patients for multidisciplinary assessment and intervention;
- failure to communicate risks, prognosis and treatment limitations effectively.

In several cases, patients were exposed to invasive or potentially harmful treatments based on diagnoses that reviewers considered uncertain or incorrect. The review also recognised harm arising from false reassurance, unrealistic expectations regarding treatability, and failure to help patients and families prepare for progressive and life-limiting conditions.

Communication with Patients and Families

Poor communication was one of the strongest and most consistent findings across both cohorts. The review repeatedly identified a lack of openness regarding diagnoses, prognosis and treatment plans. Patients and families were often not given clear explanations of conditions or involved meaningfully in decision-making. Many patients reviewed were living with progressive neurological diseases such as multiple sclerosis, Parkinson's disease and motor neurone disease. The RCP considered that these patients required honest discussions, realistic prognostic information and access to support services to allow future planning and informed decision-making. Instead, the review frequently found evidence of diagnostic ambiguity, poorly documented discussions and missed opportunities for advanced care planning.

Family testimony was particularly influential. In Cohort 1, of the 23 cases where concerns were raised, 21 were either fully or partially upheld. Families consistently described poor communication, lack of empathy, inadequate explanations and unanswered questions regarding diagnoses and inherited risk. The review acknowledged the profound and lasting impact these issues had on bereaved relatives.

Multidisciplinary Working and Professional Isolation

A further recurring finding concerned the apparent isolation of clinical practice. Across both cohorts there was limited evidence that Dr Watt routinely sought advice from colleagues, participated fully in multidisciplinary decision-making or utilised specialist expertise in complex cases. Communication with colleagues was graded poor or very poor in the majority of cases reviewed.

The review identified examples where referrals to specialist nurses, physiotherapists, occupational therapists, speech and language therapists and palliative care services were delayed or absent. In complex cases, there was often little evidence that alternative clinical opinions had been sought or acted upon. Reviewers considered this lack of collaborative practice to be a significant contributory factor to many of the shortcomings identified throughout the review.

Record Keeping

Although record keeping was not the most significant concern identified, the RCP found that documentation was frequently inadequate. Clinical notes and letters were often brief, lacked evidence of examination findings, did not record clinical reasoning and failed to document conversations with patients and families. Reviewers noted that poor documentation made it difficult to understand how diagnoses had been reached and how treatment decisions had been justified.

The full Report is published on the RQIA web site at:
https://www.rqia.org.uk/reviews/deceased-patients-review/

3.2 Executive summary of RCP Review Phase 3 Group 1 (October 2025)

The following is extracted from the RCP collated Report of all the cases reviewed in Phase 3 Group 1.

This is the third of three linked reviews commissioned by the Regulation and Quality Improvement Authority (RQIA), which is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The review of the Records of Deceased Patients in the commencement of this series of reviews, known as Phase 2, had two cohorts of records reviewed, a total of 44 patients. The findings of that Review were published by RQIA in November 2022.

In July 2024, The Department of Health asked any further families of deceased patients of Dr Watt who wished to explore involvement with the review to contact RQIA by no later than 31 December 2024.

In July 2024, the RQIA formally requested that the invited review service undertake a further phase of the review. Phase 3 families approached RQIA following the commencement of Phase 2 and were therefore unable to be included in Phase 2. Phase 3, Group 1, has involved a review of the clinical records of a further 18 deceased patients (the year of death ranged from 2004 to 2021).

A review team, comprising expert consultant neurologists, reviewed the clinical records associated with the 18 patient cases. The review team also considered written statements submitted by families of the patients. Meetings were held with family members of 15 of the 18 patients.

These meetings took place using videoconferencing software and provided an opportunity for families to share their experiences in their own words. The RQIA intends to share individual case summaries with each of the 18 families. This sharing process will be managed confidentially (now completed).

Conclusions

Across the 18 cases, two cases were considered to have represented good practice in terms of the overall quality of neurology care provided. The rest were graded as either unsatisfactory (five cases) or room for improvement (11 cases).

The cohort of cases reviewed had not been associated with concerns as part of the recall. So, it is concerning that so little good practice was found and that five cases were graded as unsatisfactory, which meant that the review team identified several aspects of care that were well below expected standards.

Almost two-thirds of the cases were graded room for improvement, which meant that aspects of the clinical care provided could have been better (nine cases), or both clinical and organisational care could have been better (two cases). Therefore, the quality of care provided to this group of patients was for the majority below the standard expected.

Clinical decision-making

This review reinforced the findings of the earlier reviews in terms of the care and management of neurological patients by Dr Watt. This included a tendency to diagnose patients quickly, at the first consultation, often without arranging investigations to confirm his suspicions, and a failure to demonstrate consideration of other possible diagnoses.

This tendency was compounded by some evidence that Dr Watt was slow to review and revisit a diagnosis, even when the patient reported symptoms that suggested other factors were at play, and where the patient's condition did not progress as expected.

The accounts of families added further insights here, with several reports that Dr Watt appeared reluctant to discuss a patient's diagnosis, was not specific regarding the diagnosis such as whether a patient had relapsing and remitting multiple sclerosis (MS), or was in a progressive phase and responded poorly when questioned whether alternative diagnoses might explain a patient's symptoms.

(MS is a condition that affects the brain and spinal cord and has three main types: relapsing-remitting; secondary progressive; and primary progressive).

The review team concluded that the diagnosis was secure in 14 of the 18 cases, with three not secure. However, it was apparent from the statements of families, and some of the meetings with family members, that they had not always been made aware when a diagnosis had altered or been updated. So even where a diagnosis was secure, the lack of documented discussion with the patient and family members regarding the diagnosis was a concern.

The previous two reviews raised issues regarding Dr Watt's diagnosis of neuropathies, specifically chronic inflammatory demyelinating polyneuropathy (CIDP - CIDP is a rare type of autoimmune disorder where the body attacks the myelin sheaths that insulate and protect the nerves).

As with the second review, there was a single case contained in this sample where Dr Watt diagnosed CIDP, and the review team considered his reasoning for reaching this diagnosis hard to follow. In fact, his diagnosis was not supported by the clinical picture or nerve conduction studies and was not secure. In another case, Dr Watt misdiagnosed motor neurone disease (MND) (with motor neurone disease (MND), messages from the motor neurones gradually stop reaching the muscle, leading them to weaken, stiffen and waste which can affect mobility, speech, eating, drinking and breathing).

He then considered a second diagnosis, multifocal motor neuropathy (MMN), which is a rare disorder in which focal areas of multiple motor nerves are attacked by one's own immune system, and proceeded to start invasive treatment before obtaining objective evidence that the patient had the condition, before two different neurologists made the correct diagnosis of posterior interosseous nerve compression/neuropathy. Posterior interosseous neuropathy (PIN), or posterior interosseous nerve syndrome, is a rare, although treatable, cause of finger and wrist drop.

This review also identified shortcomings in Dr Watt's clinical decision-making relating to three patients with MS. This included a lack of evidence to show that he requested repeat MRI brain and spine imaging to assess the disease burden when taking over the care of a patient previously diagnosed with MS, or to show consideration of alternative diagnoses, or when a patient's condition deteriorated rapidly.

Dr Watt also failed to document any examination or evidence to exclude infection, which can trigger an MS relapse, before initiating steroids or to establish whether the patient had entered a progressive phase of the condition.

Shortcomings were also identified in Dr Watt's management of some patients who were having seizure-like events, including a failure to describe in clinic letters the type of seizure and an apparent lack of consideration of investigations to establish whether seizures were epileptic or non-epileptic.

Several patients in this cohort developed dementia, alongside their neurological conditions, and Dr Watt seemed slow to recognise the presence of dementia or to revisit the diagnosis he had made at the initial consultation. There was a lack of evidence of cognitive assessment of these patients.

Prescribing decisions

As with previous reviews, several concerns were identified regarding Dr Watt's clinical decision-making around prescribing. Concerns were raised regarding the standard of prescribing in 11 of the 18 cases. These included a lack of documented discussion with patients about the side effects of prescribed treatments; unclear rationale for some of his prescribing decisions; the use of steroids in some patients; an apparent lack of monitoring of some prescribed medications; and lack of medicines reconciliation.

Death certification

There were three cases where the review team identified concerns with the recorded cause of death. These concerns related to the inclusion of relevant diagnoses on the death certificate and, in one case, uncertainty regarding the cause of death of a patient who died at home. Dr Watt did not appear to be involved in the end-of-life care for any of the patients reviewed.

Potential harm

The review team was asked to consider for each case whether any concerns gave rise to the potential for harm. Some potential for harm was identified (categorised as low, moderate or severe) in 12 of the 18 cases. In five cases the potential for low harm was identified; in six cases there was thought to be potential for moderate harm. In one case, there was potential for severe harm and specialist renal input may be required to establish whether actual harm occurred.

Follow-up

Dr Watt often followed up patients in a timely way (this phase of care was most likely to be graded as good or adequate care); however, his approach to the management of the patient's condition at follow-up appointments appeared overly focused on changing prescribed medicines or medication dose.

Communication with colleagues

Evidence of Dr Watt's communication with colleagues was most often (11 cases) graded as adequate care, in contrast to the previous review where it was more likely to have been graded as poor or very poor care. In this review, six cases were graded as poor care. However, across the cases, there was a lack of evidence that Dr Watt referred the patient to the wider multidisciplinary team, including physiotherapy, speech and language therapy and occupational therapy. The accounts of several families were that they had to pursue other avenues to secure this type of input.

Interactions with patients and families

The review team observed that there was little documented discussion by Dr Watt with patients and family members. For example, indicating discussion of the potential side effects of medicines he prescribed, or to document the patient's wishes or social situation. Of the 18 cases, 13 were graded as poor care under this heading.

This echoes the previous review, which concluded that most cases were poor care or very poor care. However, the previous review did not grade any cases as adequate or good care, and in this review, five cases were graded as adequate care under this heading.

The family statements, and the meetings with family members, contributed an additional perspective. A lack of information sharing regarding the diagnosis and prognosis was a recurring message. Descriptions of Dr Watt's approach to clinic consultations, and some reported behaviours, also gave rise to some concerns.

Perhaps the biggest issue was Dr Watt's apparent failure to facilitate a holistic approach to the care of patients with progressive neurological conditions, including consideration of their support needs, signposting to other services, and enabling advanced care planning.

Clinical record keeping

Across the three reviews, Dr Watt's approach to clinical record keeping has been observed as light on detail. He rarely documented the findings of neurological examination, and his letters contained no explanation of his clinical decisions, which made the rationale for his treatment decisions hard to follow. This review was no different and 12 of the 18 cases were graded as poor care, and a 13th case graded as very poor care, as Dr Watt's clinical letters lacked important details.

What's needed

Across the three reviews, there has been evidence that Dr Watt worked in an isolated way, with little challenge from colleagues, leading to years of unidentified poor outpatient practice. The RCP has observed that this model of care is widespread across several (mainly outpatient) specialty services across the UK, including neurology, rheumatology and dermatology.

It has highlighted lessons for the trust and the system regulator to avoid the same mistakes being repeated. A rallying call from many of the families who participated in this review was for action to be taken to prevent the same mistakes from impacting other patients and their families. This relies on strong multidisciplinary team (MDT) working and an understanding that safe and effective care is best delivered by teams, not by clinicians working in a solitary way.

It also requires cultural change, a willingness for all staff to speak up and challenge colleagues, and for all clinicians to demonstrate accountability to their patients, their colleagues and the wider health system. Regulators need to work with specialist societies and NHS trusts to agree a process that reassures the public that such services offer safe and effective care.

Learning from families

While the clinical record review was underway, the RQIA liaised with the families and carers of the 18 patients to discuss whether they wished to share any issues or concerns with the RCP review team. Those who did were asked to provide a written statement outlining their concerns.

The RCP review team considered these written statements, which were reflected in the review team's gradings, specifically with respect to interactions with patients and families and the potential for harm.

Some families also opted to meet with representatives of the RCP. The medical director of the invited review service and the review manager (an experienced lay reviewer and patient advocate) held online meetings with the families of 15 patients over 4 days in March 2025. One family also shared some excerpts from a diary kept by the patient.

Some of these families had harboured long-standing concerns regarding Dr Watt's care of their loved one. Others had been alarmed by the publicity relating to Dr Watt's practice and sought reassurance regarding the care of their family member.

A recurring question was whether the diagnosis was secure and whether the medications prescribed by Dr Watt had been appropriate. Several of the families expressed a worry that prescribed medications had worsened the patient's symptoms or even hastened their decline.

All 18 patients included in this review were deceased. Many had progressive neurological disorders, such as MND, MS or Parkinson's disease (Parkinson's disease is a condition in which parts of the brain become progressively damaged over many years) where symptoms worsen over time and can profoundly affect a patient's ability to move, eat and speak, as well as a patient's mood and cognitive state. The meetings with family members shone light on how these diseases had impacted their loved ones and the ramifications for families.

The meetings also provided an opportunity to hear about the person behind the patient. This included the careers they had achieved, in broadcasting, the civil service, business, journalism, engineering, as a homemaker and in quarry management. Families also described their loved ones before their illness – gregarious, an entertainer, full of life, fun loving, no angel, a gentleman, vivacious, headstrong, very active, loved to cook and loved food, astute and very outgoing, very much loved.

They described the role their family member played within their family and local community: our rock, would have done anything for anyone, the glue that held our family together, a great father and grandfather, there was a joke a day with daddy, the life and soul of the local community, her house was like Santa's grotto. They talked about their aspirations for the future, whether that was to travel, socialise, play sports or indulge a passion for vintage cars.

The diseases diagnosed in many of these patients ended their careers, obliterated future aspirations and led to profound physical and emotional changes for the individual, with consequences for their family networks. Many families reported that the patients had suffered with mental health issues, anxiety and depression following their neurological diagnosis.

Sadly, this is a feature of some progressive neurological disorders. The treatments prescribed to bring relief to symptoms can also be associated with side effects that present additional challenges. Good clinical care in this context encompasses clear and open communication with the patient and taking the family through the diagnosis and the pathway.

It means understanding the patient's existing support systems and being cognisant of the support family members and carers themselves need. It relies on good signposting to support services and includes anticipatory care planning, so that the patient and family members can know when to prepare for end of life, and have discussions on matters such as resuscitation status, power of attorney and capacity assessment.

Too often these elements of care were missing in the cases reviewed. The meetings with family members highlighted how they were left feeling unsupported and isolated in trying to secure care for their loved one.

Dr Watt could not be expected to meet all the needs of patients and their families in this context, but he should have done more to signpost other sources of support and to involve the wider multidisciplinary team, including physiotherapists, occupational therapists and speech and language therapists. Dr Watt's input into the patient's care was often said to focus predominantly on prescribing treatments, which reinforced the review team's observations that Dr Watt appeared to overlook the holistic aspects of care.

A recurring message was that family members felt unprepared for the patient's decline, reflecting that they were uncertain as to the specific diagnosis and prognosis. There was a recurring perception that Dr Watt was reluctant to talk about the diagnosis, amid reports that he would react unexpectedly when families questioned him regarding the diagnosis or treatment options.

This included allegedly walking out of a consultation on one occasion and leaving a doctor in training to finish the appointment, and on another occasion, remonstrating with a patient in a wheelchair causing the patient's wife to remind Dr Watt to behave professionally.

Dr Watt was thought to be reluctant to revisit his initial diagnosis when the patient's progression was not as expected. Families sometimes benchmarked the symptoms of their relatives with other people diagnosed with the same condition or had picked up comments from other clinicians that suggested more was going on than had been shared with them.

This included one patient who was diagnosed by Dr Watt with MS, which appeared to be following a secondary progressive course, but was reportedly informed by a consultant from another specialty that the medical records indicated primary progressive MS. Family members relayed that the patient had been unclear what type of MS he had, despite making numerous enquiries of Dr Watt.

Another family said they remained unclear about their relative's diagnosis and had never received a formal diagnosis. Another family talked about their relative believing that details of her diagnosis were kept from her. This patient continued in the belief that she had relapsing and remitting MS and was expected to recover and was shocked when told by a social worker that her MS had become progressive.

A family member said: 'She didn't feel like a participant in her care, instead she felt like she was a child, and people were making decisions for her'. Another patient was said to have asked Dr Watt whether he should exercise his limbs to keep strong and Dr Watt was said to have responded 'definitely not'. Family members reported that the patient 'just gave up'. Dr Watt had misdiagnosed MND in this patient.

A lack of clarity regarding diagnosis and the outlook for the patient left some families feeling they had been denied the opportunity to plan the last years with their loved one. It also meant that some patients lost autonomy to make decisions regarding their final years. One family said Dr Watt diagnosed MND and advised the patient could expect to live 10 to 20 years.

He was said to dismiss the concerns of family members who had read about a life expectancy of two to five years. (The MND Association reports that a third of people diagnosed with MND die within a year and more than half within two years of diagnosis).

The patient died within two years of her diagnosis and family members said: 'We didn't realise we had so little time'. Similar accounts were provided by families whose relatives had dementia, which Dr Watt had been slow to recognise or seemed reluctant to acknowledge at all.

One family said their relative had been 'robbed of the opportunity and choice to say what he wanted from the last years of his life'. There were also implications for social care needs assessment and capacity assessment.

Many of those who attended these RCP meetings were the adult sons and daughters of patients who had been under the care of Dr Watt. Some had first-hand experience of accompanying the patient to neurology consultations. Others relied on recollections of what their parents had told them. Dr Watt was described by one family member as 'friendly, jovial and charismatic', but also as 'bizarre and eccentric'.

Other comments were that he was 'cocky and full of himself', and 'lived in a doolally land'. Some families were left bewildered by diagnoses made quickly into the patient's initial consultation with Dr Watt, in the absence of investigations, tests or examination.

A recurring theme was that Dr Watt's approach to delivering a diagnosis lacked empathy. A tendency to joke with patients and families, who were adjusting to devastating news, was a recurring theme. Review appointments were reported to be very swift ('a few seconds' to 'five minutes').

There were several accounts that Dr Watt did not seem to have access to the patient's records and instead would jot notes on scraps of paper, often while remaining standing in the consultation room. One family reported that Dr Watt tended to speak to the patient mainly in the hospital corridor ('A lot of the chat was in the corridor').

Most of the questions raised by family members should be answered by the review team's structured judgement review of each case. However, family members also raised wider questions that extend beyond the remit of this review.

These included about the role of the Belfast Trust that employed Dr Watt and mechanisms for holding medical staff to account, as well as the trust's provision of neurology services and the support and guidance provided by care pathways.

For example, neurology clinics were described as chaotic, with patients told to arrive at the same time and then expected to wait several hours to be seen, with no apparent order.

Some family members described waiting in hot, stuffy corridors, with no accommodation made for patients who struggled with mobility or found sitting for long periods problematic. Some were critical of the neurology ward care provided at the Royal Victoria Hospital, including one account that the curtain would be left drawn around a patient suffering problems with choking and breathing, when direct supervision was needed.

Another account was of a glass of water and tablets left on a bedside table out of reach of the patient and staff uncertain who the medication was for, as well as the patient left in soiled night wear. A lack of support was described for patients diagnosed with MND, including some criticism of the trust's MND coordinator.

The accounts of families also raised questions for the regulator, the RQIA, to address, in terms of maintaining high standards of care and acting swiftly where problems arise. A recurring theme from the family statements was a wish for changes to be made to the system to ensure no other patients or families experience a similar situation.

Several families spoke of the trust they and the patient had in the medical profession and the faith they placed in Dr Watt.

One family member described how their relative was from a generation that had 'looked up to doctors' and was 'fond of Dr Watt' and gave him Christmas presents. A recurring message was that their trust in doctors had been severely shaken by their experiences with Dr Watt and the attention given to his practice. One family member said: 'Dr Watt never told us anything and what he told us was lies'.

In contrast, some families were very positive about others involved in their loved one's care. Several doctors and other staff at Mater Infirmorum Hospital (part of the same trust) were described very warmly, including palliative care staff.

It is hoped that, in time, positive experiences will help to rebuild confidence in the medical profession in Belfast.

3.3 Executive summary of RCP Review Phase 3 Group 2 (May 2026)

The following is extracted from the RCP collated Report of all the cases reviewed in Phase 3 Group 2.

This is the third of three linked reviews commissioned by the Regulation and Quality Improvement Authority (RQIA), which is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The review of the Records of Deceased Patients in the commencement of this series of reviews, known as Phase 2, had two cohorts of records reviewed, a total of 44 patients. The findings of that Review were published by RQIA in November 2022.

In July 2024, The Department of Health asked any further families of deceased patients of Dr Watt who wished to explore involvement with the review to contact RQIA by no later than 31 December 2024.

Phase 3 families approached RQIA following the commencement of Phase 2 and were therefore unable to be included in Phase 2. Phase 3, Group 1 involved a review of the clinical records of 18 deceased patients (the year of death ranged from 2004–2021). This review, Phase 3, Group 2 was formally commissioned in August 2025. It involves review of the care provided to a final group of seven patients whose families confirmed their wish for involvement in the process while the Phase 3, Group 1 review was underway and before 31 December 2024.

The review team for this final review comprised the same expert consultant neurologists as the Phase 3, Group 1 review (see section 3.2). The experts scrutinised the clinical records associated with the seven patient cases and considered written statements submitted by families of the patients.

Meetings were held with family members of the seven patients. These meetings took place using videoconferencing software and provided an opportunity for families to share their experiences in their own words. The RQIA intends to share individual case summaries with each of the seven families. This sharing process will be managed confidentially.

Conclusions

Across the seven cases, three were graded as unsatisfactory overall which meant that the review team identified several aspects of care that were well below expected standards.

The remaining four cases were graded as room for improvement overall, which meant that aspects of the clinical care provided could have been better (two cases) or both clinical and organisational care could also have been better (two cases).

Clinical decision-making

In common with earlier reviews of the care and management of neurological patients by Dr Watt, the review team saw evidence of his diagnosing patients quickly, at the first consultation, without the level of clinical examination or investigation that would be expected.

While in most cases Dr Watt followed up patients in a timely way (this phase of care was most likely to be graded as adequate care), there was a persistent lack of detailed examination at follow-up appointments. Dr Watt's approach to the management of the patient's condition appeared overly focused on changing prescribed medicines or medication dose and there were examples of Dr Watt failing to adequately investigate new or developing symptoms.

Opportunities were missed to explore differential diagnoses (other possible explanations for the symptoms) when the patient's symptoms and the trajectory of their condition strongly indicated that this was needed. In two of the seven cases the review team questioned the security of Dr Watt's diagnosis.

Prescribing decisions

The review team identified numerous concerns about Dr Watt's prescribing practice and concluded that it was not in keeping with standards expected in all seven of the cases reviewed.

A recurring theme observed to varying degrees in all cases was that Dr Watt would try multiple medications within a relatively short period of time. These were often commenced at high doses and/or doses were escalated and varied rapidly. There was insufficient documented evidence that the risk of interaction between some of the medications prescribed was appropriately considered.

The rationale for Dr Watt's prescribing was often not well documented and was not clear to the review team in some cases. Detailed advice and guidance to patients' GPs about their treatment, including monitoring arrangements, was lacking. Moreover, in each of the seven cases there was a persistent lack of discussion with patients about the side effects of the medications prescribed and how to monitor for these. In some cases the review team considered that the medications prescribed, together with the lack of guidance provided, had put the patient at risk of harm.

Death certification

There was one case where the review team identified potential concerns with the accuracy of the patient's certified cause of death. The patient was initially diagnosed with Parkinson's disease by another consultant neurologist. The diagnosis was confirmed by Dr Watt and the patient received treatment for the condition before dying suddenly at home. The review team believed there was significant evidence to indicate that the patient had multiple system atrophy (MSA) rather than Parkinson's disease.

Multiple system atrophy is a rare condition that's caused by a loss of nerve cells in the brain. This can lead to a wide range of problems with muscle control and movement.

Whereas this patient's cause of sudden death was recorded as myocardial infarction (a myocardial infarction - also known as a heart attack - is a serious medical emergency in which the supply of blood to the heart is suddenly blocked, usually by a blood clot. MSA can also be a cause of sudden death). However, the review team concluded that this uncertainty in relation to the patient's diagnosis and cause of death could not be resolved on the information available. Nor would the matter be possible to resolve at this stage by way of further investigation by the Northern Ireland coroner's service.

Communication with colleagues

Dr Watt's communication with colleagues was graded as poor in over half of the cases reviewed (four cases). These judgements were made based on the lack of guidance provided to patients' GPs about their neurological treatment (see above); a lack of input from the wider multidisciplinary team (including physiotherapists, occupational therapists and specialist nurses) in cases where the patient would have benefitted from this; and the evident lack of communication and coordination between professionals involved in the patient's care, with teams appearing to work independently of one another.

Interactions with patients and families

All seven cases were graded as poor care when considering Dr Watt's interactions with patients and their families. In all cases, the clinical records reviewed contained very little evidence of discussion with the patient or their family. Clinic letters were not copied to patients, which is considered good practice and can clarify diagnoses, treatment plans and follow-up actions as well as reducing anxiety.

There was little evidence of any discussion of treatment options and the potential side effects of medicines that Dr Watt prescribed, of practical safety advice such as in relation to driving, or of the patient's wishes. This approach may have denied patients agency in directing their own care.

There was a lack of holistic consideration of patients' needs. The review team saw no evidence that Dr Watt effectively advocated on their behalf or signposted to other services which could provide support to them and their family, and enable advanced care planning.

The accounts of family members heard as part of this review painted a mixed picture of interactions with Dr Watt. Some relatives told the review team that they and the patient had viewed Dr Watt positively at the relevant time, finding him to be kind and reassuring in his approach. Others described a more negative experience, noting that they had found Dr Watt unprofessional and lacking in empathy.

There was a sense among some family members that legitimate concerns raised by patients or their families about their diagnosis and treatment were dismissed by Dr Watt.

Clinical record keeping

For this phase of care, one case was graded as adequate care, five cases were graded as poor care and one case was graded as very poor care. Dr Watt's clinical record keeping often contrasted with that of other clinicians involved in the patient's care who were observed to write more detailed letters outlining the patient's history, examination and investigation.

Often, Dr Watt did not clearly document patients' medical history or a detailed neurological examination. His clinical letters were brief and lacked important details such as the patient's motor and non-motor symptoms, the length of time the patient had been seizure free when resuming driving or the reasons for a patient's attendance to the hospital Emergency Department.

As noted above, the rationale for prescribing decisions, including changes to medication, were often not adequately documented and were unclear to the review team.

Potential harm

The review team was asked to consider for each case whether any concerns gave rise to the potential for harm. Some potential for harm was identified (categorised as low harm in each case). It is important to note that although the review team determined that the potential clinical harm identified was at the lower end of the scale, the review team did not underestimate the psychological impact that receiving poor care from a professional in a position of trust can have on patients and their loved ones.

What's needed

This final stage of the review of the care provided by Dr Watt has further reinforced the risks of the isolated way in which he worked, with little oversight or challenge from colleagues.

The RCP observed in the previous review phases that this model of care is widespread across several (mainly outpatient) specialty services across the UK, not just neurology, and has identified lessons for the trust and the RQIA to strengthen safeguards for patients. This includes an emphasis on strong multidisciplinary team (MDT) working, a workplace culture that enables all staff to speak up and challenge colleagues, and for all clinicians to demonstrate accountability to their patients, their colleagues and the wider health system.

Learning from families

While the clinical record review was underway, the RQIA liaised with the families and carers of the seven patients to discuss whether they wished to share any issues or concerns with the RCP review team. Families were asked to provide a written statement outlining their concerns and were also invited to meet with the review team after their loved one's records had been considered.

The RCP review team considered written statements from the family of each of the seven patients, which were reflected in the gradings reached, specifically with respect to interactions with patients and families and the potential for harm.

All families opted to meet with representatives of the RCP. The medical director of the invited review service (chair of the review team) and the review manager held online meetings with the families over two days in January 2026.

Detailed case summaries of the care provided to each patient by Dr Watt and the review team's conclusions in each case will be shared with the families confidentially. Below is a summary of the themes arising from the information shared by the families in their written statements and during their meetings with the review team.

As was the case in the Phase 3, Group 1 review, some of the families involved in this review had harboured long-standing concerns regarding Dr Watt's care of their loved one. Others had been alarmed by the publicity relating to Dr Watt's practice, which was described as 'deeply troubling', and sought reassurance regarding the care of their family member.

A common question was whether the diagnosis was secure and whether the medications prescribed by Dr Watt had been appropriate. Several of the families expressed a worry that prescribed medications and/or their withdrawal had worsened the patient's symptoms or even hastened their decline. Families spoke of sharing their concerns in order to seek the truth and honour their loved one's memory.

All seven patients included in this review were deceased. Five of the patients had progressive neurological disorders, such as astrocytoma (Astrocytoma is a type of brain tumour. www.macmillan.org.uk/cancer-information-and-support/brain- tumour/astrocytoma) or Parkinson's disease, where symptoms worsen over time and can profoundly affect a patient's ability to move, eat and speak, as well as their mood and cognitive state.

One patient had a brainstem infarction (stroke) which resulted in the patient having significant neurological deficit in the form of 'Locked-in syndrome'. (Locked-in syndrome is a very rare condition where someone is conscious, but unable to move or speak. It is usually due to a stroke in the brain stem, a crucial area of the brain that controls movement and other vital body functions) and saw Dr Watt only for a short period some years later in relation to seizures. The final patient experienced symptoms which the review team thought likely to be the result of a form of migraine, but which were treated by Dr Watt as epileptic seizures.

The treatments prescribed to bring relief to symptoms of these conditions can also be associated with side effects that present additional challenges. Good clinical care in this context encompasses clear and open communication with the patient and taking the family through the diagnosis and the pathway.

It means understanding the patient's existing support systems and being cognisant of the support that family members and carers themselves need. It relies on good signposting to support services and includes anticipatory care planning, so that the patient and family members know when to prepare for end of life, and having discussions on matters such as resuscitation status, power of attorney and capacity assessment. As in previous reviews in relation to Dr Watt's practice, too often these elements of care were missing in the cases reviewed.

The meetings with family members shone a light on the person at the centre of these patient stories. Families provided insight into their relatives' personalities, their careers, interests and hobbies. These included dressmaking, calligraphy, gardening, cooking, weightlifting, golf, travel, music and dancing. Patients were described as kind, talented, thoughtful and generous; glamorous; full of life; a moral man, a bit of a character; a loving mother [with] grace and dignity; the heart of the family, a funny character, a hard grafter; and; as someone whose warmth and kindness could be seen in all that he did.

The diseases diagnosed in some of these patients led to profound physical and emotional changes for the individual, with consequences for their families. Relatives spoke of the impact on their loved ones, including deteriorating quality of life; loss of confidence, independence and dignity; and feelings of fear, anxiety and distress.

They also described how the patients had responded to these very difficult circumstances, noting 'she was inspiring and she bore her cross with great dignity and courage', 'he was determined to carry on with life as normal… he found a way to keep doing the things he enjoyed' and 'he led quite a fulfilling life… played cards… still went to dances… had family holidays'.

Families shared their own impressions of Dr Watt, as well as describing their recollections of how the patient had described him. A mixed picture was presented. Some families found Dr Watt to be 'kind, sympathetic and always [taking] time to listen', 'quite friendly' and 'reassuring'. Others were far more critical, noting that that they had found Dr Watt 'unprofessional', 'flippant', 'arrogant rather than empathetic' and 'difficult to engage with'. Dr Watt's clinics were described as chaotic, with all patients asked to attend at the same time and then having long waits for what was often a very brief consultation with Dr Watt.

Some relatives expressed their frustration with Dr Watt's response when the patient and/or their family raised concerns with him, noting that he was dismissive and often avoided difficult conversations. It was notable that in some cases relatives had concerns about Dr Watt's approach that their loved one either did not share or would not permit them to raise formally. The review team heard that this was the result of the great level of trust placed in Dr Watt by those under his care and, in some cases, the deference shown to a professional of his stature by many of the patient's generation.

Families described the impact on their loved one of receiving their diagnosis from Dr Watt, often after a short initial consultation and with little or no information provided about what to expect in terms of their treatment and the progression of their condition. The review team heard that multiple medications would be prescribed without discussion or a written record of this being provided to the patient, with one relative commenting 'I thought why not send a letter home so we know exactly what's going on?'.

Some families told the review team that Dr Watt had provided their relative with his personal mobile phone number and urged them to contact him as required. In some cases this provided reassurance at the time, but subsequently families questioned the appropriateness of this arrangement.

This was particularly the case where family members recounted Dr Watt providing patients with advice, including changes to their medication, during calls to his mobile phone out of hours and without any follow up. Dr Watt's input into the patient's care was often said to focus predominantly on prescribing treatments without signposting to other sources of support or referrals to the wider multidisciplinary team including physiotherapists, occupational therapists and speech and language therapists. Where professionals from other disciplines were involved, families generally found care to be of a good standard and some highlighted in particular the very supportive approach taken by those involved in their relative's end of life care.

Two families highlighted the lack of neurological care provided to their relative from mid-2017 after Dr Watt had ceased to practise. In one case the patient's family described repeatedly contacting the neurology service over a period of months to seek support and being advised that someone would call back to arrange this. No appointment was offered until after the patient had died. Another family reported that around this time, the patient was overdue a follow-up appointment with Dr Watt and was experiencing delirium.

The patient was referred to another consultant neurologist who advised that the patient had been undertreated and recommended changes to his medication. The patient's family told the review team that the patient's symptoms improved within days of this consultation, describing the difference as like 'night and day'. At this point the patient was also referred to a Parkinson's specialist nurse for the first time, who the family described as 'fantastic'. The patient's relatives questioned why this level of support had not been available to the patient while under Dr Watt's care.

Both Phase 3 reviews (Group 1 and Group 2) have highlighted the impact that direct experiences with Dr Watt, as well as the wider publicity about his practice, have had on the level of trust in doctors and in the healthcare system. Families were keen to stress that they did not want the mistakes of the past to be repeated and that changes must be made to the system to ensure that no other patients or families experience a similar situation.

The review team wish to commend the families for their courage in coming forward and for their openness in sharing incredibly difficult experiences.

4. EXPERT PANEL RECOMMENDATIONS

The RCP collective review reports set out recommendations. Some of these recommendations related to specific cases reviewed. Those require follow up actions with the Belfast Trust, and some directed towards RQIA seek system wide actions. Each of these have been set out below. For those recommendations that relate to individual patient cases, this report indicates the nature of these without identifying individuals, and the actions taken to address those are also referred to. For the recommendations that relate to follow up actions with Belfast Trust and those directed at RQIA, the full description of the recommendation from the RCP reports is included and a description of the actions taken by RQIA to take forward these recommendations.

Across all Phases of the Reviews, the RCP made five recommendations that relate to individual cases, these are set out below.

RCP Recommendations made relating to individual cases

<table>
<tr><th>Phase</th><th>RCP Recommendation</th><th>Action Taken</th></tr>
<tr><td>Phase 2
Cohort 1</td><td>The RQIA should consider how to respond to the concerns identified by the review team with respect to the recorded cause of death in five cases</td><td rowspan="2">Following Family Liaison Team (FLT) engagement with families, a total of ten cases, including the eight cases referenced within the RCP recommendations (see left), were referred to the Coroner's Office. The Medical Director, Belfast Trust, was advised accordingly.

The Coroner's Office has confirmed outcomes regarding the ten referrals as follows:
Amendments made to six death certificates
Four inquests pending</td></tr>
<tr><td>Phase 2
Cohort 2</td><td>The RQIA should consider how to respond to the concerns identified by the review team with respect to the recorded cause of death in three cases</td></tr>
</table>

Phase	RCP Recommendation	Action Taken
Phase 2 Cohort 2	The RQIA should share the review team's concerns regarding the management of one case with this patient's family members. This case concerned a patient who committed suicide. The review team graded this case unsatisfactory and believed its findings should be shared with the family.	A review of the patient's medical records was undertaken by Belfast Trust. Contact details were identified. Several attempts were made to make contact with the family with no success. Belfast Trust subsequently made contact with the patient's GP who confirmed that they did not hold any available/up to date contact details for the patient's family.
Phase 3 Group 1	The RQIA should consider the review team's conclusion in one case that the death certificate was not an accurate reflection of the factors underlying the patient's death. RQIA may decide to refer this case to the Coroner's Service Northern Ireland for consideration of coronial inquest.	Following Family Liaison Team (FLT) engagement with families, a total of four cases, including the two cases referenced within the RCP recommendations (see left), were referred to the Coroner's Office. RQIA referred the additional two cases to be considered by the Coroner. The Coroner's Office have confirmed they have written to the Medical Director, Belfast Trust, to request a review of the cause of death in two cases. The other two remain with the Coroner's office, for consideration of the death certificate's accuracy.
Phase 3 Group 1	The RQIA should consider the review team's conclusion in one case that the death certificate was not an accurate reflection of the factors underlying the patient's death	

RCP Recommendations that relate to follow up with Belfast Trust on service-related issues

Phase	RCP Recommendation	Action Taken
Phase 2 Cohort 1	The RQIA will need to consider the implications of the finding of this review that 14 of the 29 cases (48%) were found to be unsatisfactory, for its wider consideration of the cases included in the recall of patients who died.	This was from the earlier review phase to which RQIA gave consideration and evaluation, and provided a summary report of its findings, shared with the DoH and published on the RQIA website. This consideration is part of the planning for a further phase of the review of records of deceased patients, which continued under Phase 3.
Phase 2 Cohort 1	The RQIA should consider the potential for harm arising from concerns identified by the review teams with respect to 13 cases.	RQIA gave consideration and documented its findings and published these from this Phase. Methodologies that could be used in future record reviews included the potential for stratification of cases on the basis of particular diagnoses of concern. Since then, a further review of cases has been taken forward on the basis of family requests. This is referred to as Phase 3.

Phase	RCP Recommendation	Action Taken
Phase 2 Cohort 1	The RQIA should liaise with the Belfast Trust to follow up on the concerns raised by family members with respect to eight cases. The RQIA should seek assurance that the Belfast Trust has taken steps to protect patients, e.g. how single-handed unsupervised practice can be prevented in the future.	RQIA has liaised with the Belfast Trust who were advised on proposals in development at that time to ensure the consultant workforce is organised into effective teams with supervision arrangements that will provide assurance to the public about the safety and quality of care. These issues formed part of the scope of the Independent Neurology Inquiry (INI) and its recommendations. Recommendation 15 - ***The NI Department of Health should emphasise to healthcare organisations the potential dangers of lone working and to develop guidance on the many ways in which it can be avoided.*** Assurance processes have been put in place by the DoH re each of the Recommendations being implemented from the INI.
Phase 2 Cohort 2	The RQIA will need to consider the implications of the finding of this review that more than half of the 15 cases – 53% (eight cases) – were found to be unsatisfactory, for its wider consideration of the cases included in the recall of patients who died.	The findings from this original phase of the Review has been set out by RQIA, shared with the DoH and published on the RQIA website. This has also led to RQIA making legacy commitments to address the culture across HSC, which is at the heart of these issues.

Phase	RCP Recommendation	Action Taken
Phase 2 Cohort 2	The RQIA should consider the potential for harm arising from concerns identified by the review teams with respect to 9 cases.	RQIA has considered the potential for harm in these cases. In addition to the cases highlighted, RQIA has also taken a broader view of harm to include the continued psychological impact on families of deceased relatives who received suboptimal and unacceptably poor quality of care, many of whom RQIA met with during the course of this review.
Phase 2 Cohort 2	The RQIA will need to consider whether these findings warrant further attention to cohorts of deceased patients who were diagnosed by Dr Y with epilepsy.	RQIA gave consideration and documented its findings and published these from this Phase. Methodologies that could be used in future record reviews included the potential for stratification of cases on the basis of particular diagnoses of concern. Since then, a further review of cases has been taken forward on the basis of family requests. This is referred to as Phase 3.
Phase 2 Cohort 2	The RQIA will need to consider whether the findings in this review relating to a single case of neuropathy (CIDP), when combined with two cases of concern in the previous review, warrant further attention to cohorts of deceased patients who were diagnosed by Dr Y with CIDP or similar neuropathies.	RQIA has given consideration to this and documented its position on options for future work and submitted these to the Department of Health. It was considered that following the initial review phase that further reviews would be on the basis of families who wished their loved ones case records to be reviewed. That is known as Phase 3.

Phase	RCP Recommendation	Action Taken
Phase 3 Group 1	The findings in this review relating to a single case of neuropathy (CIDP), when combined with the previous reviews, should be shared with the neurology team at Belfast Trust, as they raise questions over the approach to diagnosing CIDP or similar neuropathies, and associated treatment pathways.	These latter two recommendations have been identified in the review of case records from Phase 3. This will now be followed up with Belfast Trust by RQIA.
Phase 3 Group 2	Concerns have been identified about failures to ensure that patients received appropriate neurological care during the period when Dr Watt was on an extended period of leave. The RQIA should therefore seek assurances from the Trust that its contemporary neurology service is providing high quality, consistent and responsive care to patients and that its capacity is appropriate to the population it serves.	These latter two recommendations have been identified in the review of case records from Phase 3. This will now be followed up with Belfast Trust by RQIA.

RCP Recommendations that relate to wider service application

These Recommendations were made against both Phases of Reviews and all cohorts and groups.

Recommendation	Action
The RQIA should consider making it mandatory for clinicians in Northern Ireland to copy most **outpatient clinic letters** to patients. The Academy of Medical Royal Colleges goes further and encourages doctors to write most of their outpatient letters directly to patients and send a copy of the letter to the patient's general practitioner. See: https://www.aomrc.org.uk/wp-content/uploads/2026/06/Please_write_to_me_update_130426.pdf	In Northern Ireland (NI) on 23 May 2022, the DoH formally endorsed NICE's guideline on **shared decision making**, which sets out the importance of writing clinical letters directly to the patient. The recommendation is reference 1.2.20: *"1.2.20 When writing clinical letters after a discussion, write them to the patient rather than to their healthcare professional, in line with Academy of Medical Royal Colleges' guidance on writing outpatient clinic letters to patients https://www.aomrc.org.uk/wp-content/uploads/2026/06/Please_write_to_me_update_130426.pdf Send a copy of the letter to the patient (unless they say they do not want a copy) and to the relevant healthcare professional."* The implementation of the NICE guidelines falls to HSC Trusts and the Strategic Planning and Performance Group (SPPG - part of the Department of Health) who have a role to monitor progress and compliance. To aid this process it is understood that a regional stakeholder Group, led by the Public Health Agency (PHA), was established to support the implementation of the regional elements of the NICE guidance, and in May 2024, the group revised its terms of reference to provide greater focus on a number of key issues including that clinical letters be addressed to patients. The adoption of the NICE guidelines secures adoption across the HSC system and the role of SPPG provides a means of monitoring its implementation.

Recommendation	Action
The RQIA should consider the wider implications of this review for clinicians working in an **isolated way**. Whilst the findings here are specific to neurological services, the RQIA should consider whether health services in Northern Ireland are able to demonstrate the type of multidisciplinary team working and culture of open and constructive challenge expected from contemporary health services.	The INI includes two recommendations (15 and 42) regarding "lone working", which are not specific to neurological services. Recommendation 15: ***The NI Department of Health should emphasise to healthcare organisations the potential dangers of lone working and to develop guidance on the many ways in which it can be avoided. (Action owner: Department of Health)*** Recommendation 42: ***Healthcare organisations should make every effort to provide consultants with opportunities to avoid lone working. It should be made clear that consultants do not have the right of veto, and that complicated "workarounds" are rarely required or acceptable. (Action owner : HSC Trusts)*** A regional group was established to provide assurance on the implementation of all the Recommendations - the Inquiries Implementation Programme Management Board (IIPMB) Assurance Sub-Group met to scrutinise and agree INI Recommendation Assurance Frameworks for all INI Recommendations. In July 2025 the IIPMB Assurance Subgroup Independent Chair, held final compliance meetings with all HSCNI Trusts. The DoH has advised that work to implement recommendations 15 and 42 remains ongoing. Whilst the DoH has advised it is assured that healthcare organisations are aware of the need for avoidance, identification, control and mitigation of the potential risks of lone working, the DoH is currently developing guidance to support healthcare organisations in line with the relevant Assurance Frameworks for each of the recommendations.

5. EVALUATION OF FAMILY INVOLVEMENT IN THE REVIEW PROCESS

Independent Evaluation from Phase 2 Families

Following publication of Phase 2 of the Expert Review (November 2022) an independent evaluation was commissioned by RQIA to understand the experiences of family members who had participated in the Review process, and to identify opportunities for improvement in future engagement processes.

The findings demonstrated a mixed experience for families. Those who participated in the evaluation generally expressed that they valued the support provided by the RQIA Family Liaison Team and welcomed access to counselling services through the Inspire Wellbeing service. Several family members reported that being listened to and having an opportunity to share their experiences provided a sense of relief and acknowledgement.

However, the review process also had a significant emotional impact. Most family members found recounting the circumstances surrounding their loved one's care, treatment and death to be distressing, with some indicating that participation reopened painful memories and negatively affected their grieving process. A small number of family members also reported that the review process itself was difficult, particularly due to the lengthy timescales involved between initial engagement and receipt of the final case summary report. In certain cases, families expressed that the review was unable to provide all the answers they had hoped for.

Levels of satisfaction varied among families:

- approximately half of those involved in the evaluation were satisfied with both the support provided by RQIA and the outcomes of their individual review reports for their loved one;
- around one quarter were satisfied with the support received but were dissatisfied with the findings of their individual reports;
- less than one quarter expressed lower levels of satisfaction with RQIA's support, with concerns primarily focused on the review process rather than the support arrangements themselves.

The evaluation highlighted the importance of ensuring that families are fully informed about the benefits, limitations, emotional impact and potential duration of participation before deciding whether to become involved. As a result, RQIA committed to strengthening communication, expectation management and support arrangements for families participating in any future phase of the Expert Review, and this has been applied in undertaking the Reviews for Phase 3 families.

Reflecting on the learning from the Phase 2 Review

The Regional Ethics Committee had advised, in advance of undertaking the further reviews referred to as Phase 3, that the review approach must ensure families were treated fairly and given the opportunity to participate, if that was their personal and informed choice. So before progressing the Phase 3 reviews, families needed to be fully informed of both the benefits and limitations of a clinical record review so they could make an informed decision about participation.

Pre-engagement meetings with Phase 3 families were established and had several key objectives:

- to understand what families hoped to achieve from participation;
- to explain the purpose, benefits and limitations of an expert clinical record review;
- to discuss alternative routes available to families, including complaints processes, compensation claims, coronial investigations and PSNI investigations;
- to determine whether families still wished to participate after receiving this information;
- to identify any additional support needs, including counselling, advocacy and psychological support;
- to gather information that would help shape and inform the design of any future phase of the review.

These meetings were held in formats chosen by the families, including face-to-face, virtual and telephone engagement, ensuring an accessible and sensitive approach.

Seeking Answers

Throughout the conversations, families consistently expressed a desire for answers regarding the care and treatment received by their loved ones. All families stated that obtaining answers was their primary motivation for involvement. Many believed that receiving independent expert scrutiny of the records would help them gain understanding and, potentially, a degree of closure.

Families also highlighted two other important themes:

- System Improvement: Many wanted assurance that lessons had been learned and that changes would prevent similar failings affecting other patients and families in the future.
- Accountability: Some families hoped individuals or organisations would be held accountable. Discussions helped clarify what a clinical review could and could not achieve, including the fact that it could not deliver justice or impose sanctions.

Listening to families provided important insight into the impact of unresolved trauma. Some families described ongoing distress linked to their experiences and difficulties navigating complex health and social care systems. Others highlighted the need for clear communication, accessible information and timely support throughout the process.

Families also shared practical preferences that will help shape future engagement. Most expressed a wish to tell their stories directly to an expert panel, preferably through face-to-face meetings. The majority requested regular progress updates throughout the review process and stated their preferred methods of communication.

The meetings reinforced lessons from earlier evaluations that participation in such reviews can be emotionally demanding. As a result, families welcomed the availability of counselling services, advocacy support and tailored information. RQIA learned that support needs are likely to increase during key stages of the review process, particularly when families share their experiences or receive final reports.

The meetings also demonstrated strong ongoing interest in participation.

Making Improvements to the Review Process

As a result of engagement with Phase 3 families, and the learning from the independent evaluation from the families in Phase 2, the approach to the Phase 3 Review included:

- establishing clear communication arrangements, tailored to individual family preferences regarding frequency of contact and method of updates;
- providing trauma-informed support throughout the review process;
- ensuring counselling, advocacy and psychological support services were available to families via Inspire Wellbeing (and expanded if required);
- direct access to RCP representatives undertaking the Review - this was new to Phase 3 review;
- a review of language used in the reporting documentation.

RQIA also recognised the importance of avoiding unnecessary delays and maintaining trust through open, honest and transparent communication.

6. LEGACY COMMITMENTS

As a result of the learning identified as part of the Expert Review, RQIA made a number of commitments known as 'Legacy Commitments' to support improvements in the Health and Social Care System. The details of these were set out in the published report from the Phase 2 review, in November 2022.

These legacy commitments included:

- to influence the training and development of health care professionals; so that the importance of compliance with clinical standards and guidelines, and of effective communication with patients, openness and active listening to capture their concerns is made obvious;

- to strengthen the assessment of a safety culture, particularly around evidence of listening to patients and families, and evidence that staff feel safe to challenge each other and raise concerns.

These legacy commitments were taken forward with the development of two key programmes, co-produced with others to ensure a shared ownership across the whole HSC system. The two are: an e-learning programme 'Building a Safe and Compassionate Culture within HSC' accessible to all HSC staff; and 'Being Human' a co-produced HSC Safety Culture Framework.

E-Learning: 'Building a Safe and Compassionate Culture within HSC'

This legacy action has seen the development of an e-learning programme accessible via the HSC e-learning platform to all HSC organisations. It is called 'Building a Safe and Compassionate Culture within HSC'.

The programme was developed through co-production involving professional bodies and others to devise a programme that would support clinicians and all staff across the HSC service to reflect on what it takes to promote a positive patient safety culture in individual and team practices and to influence practice and behaviours. The Programme features the story of Stephen Sparkes, (as told by his mother Norma Sparkes, in short video clips), and covers the following topics:

- evidence-based practice;
- person-centred care;
- listening, hearing and acting;
- candour;
- creating safe and compassionate cultures for clinicians;
- governance.

At this stage over 1,000 staff across the HSC have completed the programme.

Key Themes Identified by Participants

The findings show that participants regarded the programme as relevant, informative and directly applicable to their roles:

- 94.8% agreed or strongly agreed that the e-learning was informative and relevant to their work;
- 94.6% agreed or strongly agreed that they had gained knowledge and insight into issues important for creating a safe and compassionate culture;
- 92.8% agreed or strongly agreed that they felt confident in applying the knowledge gained to their everyday work;
- 90.8% agreed or strongly agreed that the programme would influence behaviours for themselves and colleagues.

Across all four questions, "Strongly Agree" was consistently the most common response, ranging from 53% to 61%, while negative responses were extremely low. This demonstrates strong confidence in both the quality of the programme and its practical value for staff.

1. The Power of Lived Experience

The most powerful and frequently referenced aspect of the programme was the inclusion of Stephen's story and the testimony of his mother, Norma Sparkes. Participants repeatedly described this element as impactful, moving and memorable.

Hearing directly from a family affected by adverse events helped staff connect emotionally with the importance of compassionate care and safety. Participants commented that hearing from those directly affected provided a human perspective that brought the learning to life and reinforced why a culture of openness, learning and improvement matters.

2. Learning Through Real Experiences

Many respondents highlighted the value of hearing real-life accounts from patients, carers and families. These personal narratives were viewed as more meaningful than traditional training approaches because they demonstrated the real consequences of both good and poor practice.

Participants reported that the use of authentic experiences increased their understanding of the impact healthcare services can have on individuals and families and encouraged deeper reflection on their own roles and responsibilities.

3. Psychological Safety, Openness and Speaking Up

A significant theme throughout the feedback was the importance of psychological safety and the promotion of open, honest communication. Participants valued the programme's emphasis on creating environments where concerns can be raised safely and where staff feel supported to challenge poor practice and learn from mistakes.

Many respondents identified speaking up, candour and supportive leadership as critical components of building a safe and compassionate culture. These themes were frequently mentioned as important learning points that participants intended to take back into practice.

4. Practical Relevance to Everyday Work

Feedback indicates that staff found the programme highly relevant to their day-to-day roles. The strong agreement scores relating to confidence in applying learning suggest that participants could clearly see how the programme's messages could be translated into practice. Respondents particularly valued the opportunity to connect learning with real-life scenarios and practical examples, helping them understand how culture, behaviours and communication influence patient outcomes.

5. Accessible Design and Learning Resources

Participants were complimentary about the programme's structure, presentation and accessibility. Many described it as well designed, easy to navigate and engaging. The combination of different learning formats, family perspectives, psychological insights and supporting resources was viewed positively, helping to maintain engagement and support learning across different professional groups.

6. Bringing Important Learning Together

Staff appreciated the way the programme consolidated learning from inquiries, policies, guidance and evidence into a single accessible resource. Participants noted that this helped improve understanding of both individual and organisational responsibilities in creating safer services.

Additional Observations

Many respondents expressed appreciation to the programme developers and contributors, with comments describing the programme as informative, valuable and thought-provoking. A recurring recommendation was that the training should become mandatory for all Health and Social Care staff, reflecting participants' belief in its importance and relevance.

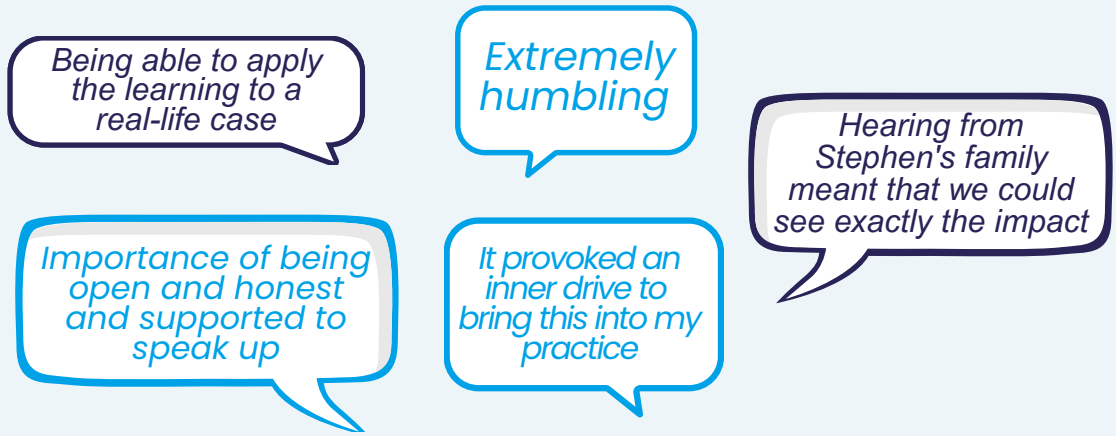
While feedback was overwhelmingly positive, a small number of respondents highlighted concerns about whether organisational cultures consistently reflect the principles promoted within the training. These comments provide a useful reminder that education should continue to be supported by visible organisational commitment to openness, learning and psychological safety.

Conclusion: Positive Impact on Practice

The evaluation findings provide strong evidence that the e-learning programme has had a meaningful impact on participants' understanding of patient safety, compassion, openness and professional responsibility. The programme appears to have successfully translated complex cultural concepts into practical learning that staff feel able to apply within their own working environments.

Perhaps most significantly, participants described being personally affected by the stories and experiences shared throughout the programme. Comments highlighted how the learning encouraged reflection, reinforced the importance of speaking up, and strengthened commitment to compassionate and person-centred practice. Several respondents reported feeling motivated to change their behaviours and support positive cultural change within their teams.

Illustrative comments included:



Taken together, these narratives suggest that the programme has done more than simply increase knowledge. It has encouraged participants to reflect on their own practice, reinforced the importance of compassionate care and patient safety, and inspired many to contribute positively to building a more open, supportive and learning-focused culture.

The 'Being Human' Framework

'Being Human' is the name given to the co-produced HSC Safety Culture Framework. The Framework was developed through co-production with the involvement of a wide number of stakeholders across the health and social care system including people with lived experience. Similar to the e-learning programme, its origins are in the legacy commitments from the review of the records of deceased patients.

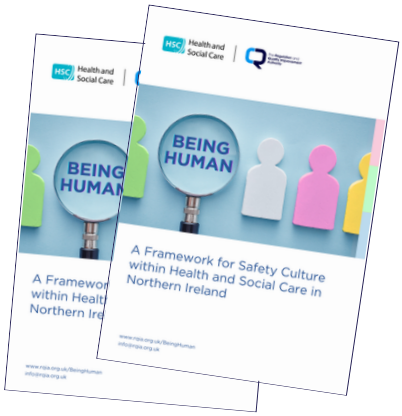
The Being Human Safety Culture Framework recognises that patient safety is not solely dependent on policies, procedures and standards, but on the behaviours, relationships and values that create the culture in organisations that shape how care is delivered every day. The framework provides a practical guide for creating and sustaining an environment where patients are safer, staff are supported, and learning is a priority.

The framework is structured around **three domains**:

1. Commitment to Patient Safety and Staff Wellbeing

The first domain establishes the foundations of a safe and effective organisation. It promotes a shared understanding that patient safety is everyone's responsibility, from frontline staff to Trust Boards, while recognising that boards hold ultimate accountability for safety.

A "floor to board" commitment ensures that patient safety remains a priority at every level of the health and social care system.



Key elements include:

- collective accountability for patient safety;
- strong governance and board oversight;
- open sharing of safety and wellbeing information;
- consistently safe, evidence-based care;
- tackling health inequalities as a patient safety issue;
- supporting staff wellbeing and preventing burnout;
- valuing diversity, inclusion and belonging;
- listening actively to patients, families and staff.

A key strength of this domain is its recognition that staff wellbeing and patient safety are closely linked. Staff who feel supported, valued and psychologically safe are more likely to provide high-quality care, raise concerns and contribute to improvement. The framework explicitly promotes safe staffing, workforce development, wellbeing support, and compassionate management practices.

2. Compassion, Civility and Respect

The second domain focuses on the quality of relationships within health and social care organisations. It emphasises compassionate leadership, effective teamwork and person-centred care. The framework recognises that safety is improved when people treat one another with dignity, fairness and respect.

Key components include:

- compassionate and inclusive leadership;
- psychological safety within teams;
- civility, kindness and professionalism;
- empowering patients and families as partners in care;
- listening, hearing and acting on concerns;
- fair and restorative responses when incidents occur;
- promoting openness and candour across organisations.

The Being Human Framework addresses behaviours such as bullying, harassment and incivility, recognising their negative impact on patient outcomes. It promotes psychologically safe environments where staff can ask questions, challenge decisions and discuss mistakes without fear.

The framework also places a real emphasis on openness with patients and families when harm occurs. Meaningful apologies, honesty, transparency and compassionate engagement are seen as critical to maintaining trust and supporting learning.

3. Curiosity and Constructive Challenge

The third domain promotes a learning culture. It seeks to replace fear, defensiveness and blame with curiosity, reflection and continuous improvement. The framework acknowledges the impact of fear and trauma within healthcare systems and promotes approaches that encourage openness and learning.

Its key elements include:

- tackling fear and defensive behaviours;
- encouraging early engagement and resolution of concerns;
- supporting constructive feedback and challenge;
- encouraging staff to speak up;
- creating time and space for reflection;
- sharing learning, from excellence and harm, in meaningful ways that improve practice.

A notable feature is the emphasis on "just culture" principles. Rather than blaming individuals for mistakes, organisations are encouraged to understand the wider system factors which contribute to incidents.

Accountability remains important, but the focus is on learning and prevention rather than punishment.

The Being Human Framework is a vehicle to support the whole health and social care system to create and sustain a positive patient safety culture

- By promoting psychological safety, compassionate leadership and just culture principles, the framework seeks to ensure staff are enabled to speak openly about risks, mistakes and opportunities for improvement. This leads to earlier identification of problems and improved patient outcomes.

- The framework recognises the direct relationship between staff wellbeing and patient safety. By encouraging organisations to address workload pressures, moral distress and workforce support needs, it helps create healthier workplaces. A workforce that feels valued and supported is more resilient, more engaged and better able to deliver safe care.

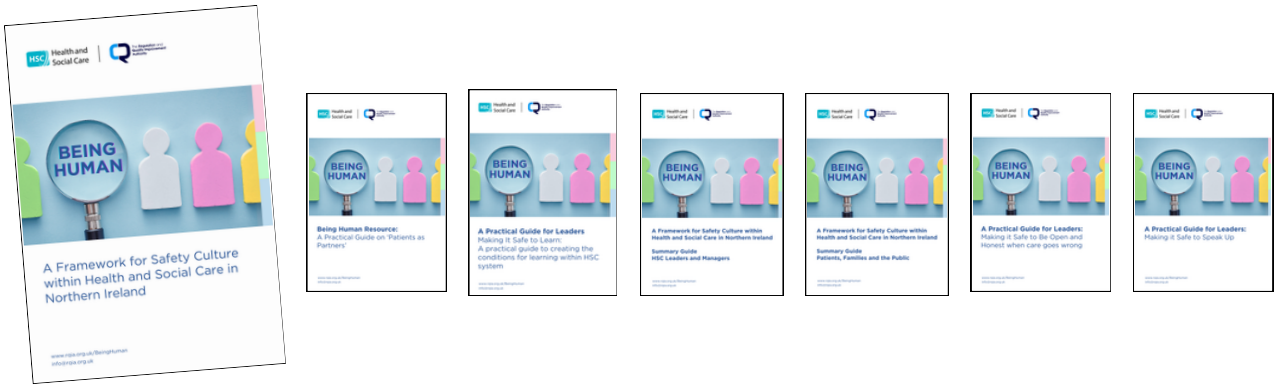
- The framework moves organisations away from blame and towards learning. Through reflection, constructive challenge, feedback and meaningful sharing of lessons learned, it encourages continuous improvement. This helps ensure that incidents, complaints and concerns become opportunities for learning rather than sources of fear.

- By treating patients and families as partners, listening to their experiences and involving them in decisions, the Being Human framework strengthens patient-centred care and helps identify opportunities to improve safety and quality.

The Being Human Framework has been co-produced by the HSC whole system with people with lived experience.

The Framework is now being tested and used across HSC organisations and each HSC Trust has identified a Being Human Champion and Ambassador to drive its adoption across the organisation.

An ECHO-enabled network (facilitated learning sessions) or 'community of practice' from September 2026 will bring those leaders together to share learning and good practice.



REFERENCES

1. RQIA Review of The Governance Arrangements of Outpatients Services in the Belfast Health and Social Care Trust with a Focus on Neurology Services and Other High Volume Specialities, RQIA, February 2020. Available at: https://www.rqia.org.uk/download/10/deceased-patients-review/4928/review-of-bhsct-outpatients-service-february-2020.pdf

2. Report of the Independent Neurology Inquiry, June 2021, Available at: https://wayback.archive-it.org/11112/20220922101418/https:/www.neurologyinquiry.org.uk/

3. Report on the Expert Review of Records of Deceased Patients (Neurology), November 2022. Available at: https://www.rqia.org.uk/reviews/deceased-patients-review/

NOTES

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