Royal College of Physicians

Setting higher standards

Invited Reviews

Report of the clinical record review for

Regulation Quality Improvement Authority on 28–29 January, 3 February and 3, 4, 20 and 21 March 2025

Contents

1 Executive summary

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 arises from a recall in 2018 of 2,500 patients who had been under the care of Dr Michael Watt, a former consultant neurologist who was employed by Belfast Health and Social Care Trust[1] ('the trust') until mid-2017. The recall was instigated by the trust following its internal review process and subsequent request to the Royal College of Physicians (RCP) to review a series of patients who had been under his care. Patients who had consulted Dr Watt privately were also included in the recall. The Department of Health in Northern Ireland has accepted 'that the events which led to the recall of patients of Dr Michael Watt … let many patients and their families down' and has apologised unreservedly for the distress this caused.[2]

In May 2018, the permanent secretary in Northern Ireland requested that the RQIA conduct an expert review of clinical records of all patients or former patients of Dr Watt in the preceding 10 years. The RQIA decided to undertake this review in a staged process to maximise learning. The RCP and the Association of British Neurologists (ABN) agreed to conduct the reviews under the auspices of the invited review service.

Phase 1 was focused on planning. Phase 2, group 1, involved reviewing the clinical records of 29 deceased patients identified by the RQIA following concerns raised by the patients' relatives about the care provided by Dr Watt. Phase 2, group 2, involved reviewing the clinical records of 16 deceased patients, who were selected for review as they were due to be seen as part of the recall but sadly died before this could happen. These phases were undertaken in 2021, and final reports were issued to the RQIA in October 2022. RQIA published the Phase 2 reports in November 2022.

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). Phase 3, group 2, has yet to be commissioned.

A review team, comprised of expert consultant neurologists (section 3.3), reviewed the clinical records associated with the 18 patient cases. The review team also considered written statements submitted by families of the patients. See section 3.2 for details of the approach to this review. 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. See section 1.1 for details. The RQIA intends to share individual case summaries with each of the 18 families. This sharing process will be managed confidentially.

[1] www.belfasttrust.hscni.net
[2] www.health-ni.gov.uk/news/independent-neurology-inquiry-implementation-plan-published

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)[3] or was in a progressive phase) and responded poorly when questioned whether alternative diagnoses might explain a patient's symptoms. 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).[4] 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 (section 4.1.8). In another case, Dr Watt misdiagnosed motor neurone disease (MND),[5] then considered a second diagnosis (multifocal motor

[3] Multiple sclerosis (MS) is a condition that affects the brain and spinal cord. There are three main types of MS: relapsing and remitting, secondary progressive and primary progressive. www.nhs.uk/conditions/multiple-sclerosis

[4] CIDP is a rare type of autoimmune disorder where the body attacks the myelin sheaths that insulate and protect the nerves.

[5] 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. www.mndassociation.org/about-mnd/mnd-explained/what-is-mnd

neuropathy)[6] and proceeded to start invasive treatment before obtaining objective evidence that the patient had the condition, before two different neurologists made the correct diagnosis (posterior interosseous nerve compression / neuropathy)[7] following single consultations.

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.[8] For details, see section 4.1.9.

Death certification

There were three cases where the review team identified concerns with the recorded cause of death (section 4.1.10). 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. For details see section 4.1.11.

[6] Multifocal motor neuropathy (MMN) is a rare disorder in which focal areas of multiple motor nerves are attacked by one's own immune system. www.gaincharity.org.uk/information-hub/mmn-multifocal-motor-neuropathy
[7] Posterior interosseous neuropathy (PIN), or posterior interosseous nerve syndrome, is a rare although treatable cause of finger and wrist drop. https://pmc.ncbi.nlm.nih.gov/articles/PMC4831403
[8] Medicines reconciliation is the process of accurately listing a patient's current medicines.

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. See section 4.1.11 for details.

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, as detailed at section 4.1.7.

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.

1.1 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.[9] 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,[10] 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

[9] These were the families of the following patients: RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx, RCPxxxx.

[10] Parkinson's disease is a condition in which parts of the brain become progressively damaged over many years. www.nhs.uk/conditions/parkinsons-disease

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 2 to 5 years (the MND Association reports that a third of people diagnosed with MND die within a year and more than half within 2 years of diagnosis).[11] The patient died within 2 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

[11] www.mndassociation.org/about-us/who-we-are/mnd-key-facts

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 '5 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 Health and Social Care 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 nightwear. 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[12] (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.

[12] www.belfasttrust.hscni.net/hospitals/mater

2 Recommendations

Key for timelines for implementing recommendations:

> **Short term (0–6 months)** – action should be completed within 6 months of receipt of the invited review report.

> **Medium term (6–12 months)** – action should be completed within 12 months of receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

> **Long term (12–24 months)** – action should be completed within 24 months of receipt of the invited review report. Planning for actions resulting from these recommendations should start as soon as possible.

a. The RQIA should consider the review team's conclusion in case **RCPxxxx** 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 for coronial investigation.[13] This may provide a route to securing specialist renal opinion on the potential impact of pergolide[14] in the patient's renal failure, and whether the patient had retroperitoneal fibrosis and came to harm.	**Short term**
b. The RQIA should consider the review team's conclusion in case **RCPxxxx** that the death certificate was not an accurate reflection of the factors underlying the patient's death.	**Short term**
c. 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 Health and Social Care Trust, as they raise questions over the approach to diagnosing CIDP or similar neuropathies, and associated treatment pathways.	**Medium term**
d. As with the previous RCP Phase 2 review, 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 GP. See: www.aomrc.org.uk/reports-guidance/please-write-to-me-writing-outpatient-clinic-letters-to-patients-guidance	**Long term**
e. As with the previous RCP Phase 2 review, the RQIA should consider the wider implications of this review for clinicians working in an isolated way.	**Long term**

[13] www.health-ni.gov.uk/sites/default/files/publications/health/Guidelines%20for%20Notifying%20the%20Coroner%20of%20a%20Death.pdf

[14] Pergolide is a dopamine agonist. It is used to treat Parkinson's disease although other treatments are often preferred because it is associated with a small risk of fibrotic reactions, as a side effect of the treatment. www.patient.info/medicine/pergolide-for-parkinsons-disease

	While 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.	

3 Introduction and background

In May 2018, the permanent secretary in Northern Ireland requested that the Regulation and Quality Improvement Authority (RQIA) conduct an expert review of clinical records of all patients or former patients of Dr Watt in the preceding 10 years. A formal direction of this was also issued by the chief medical officer on 10 May 2018. It was determined that the expert review of records of deceased patients of Dr Watt would be undertaken in phases.

The RQIA commissioned the Royal College of Physicians (RCP) to conduct an expert review of records of deceased patients of Dr Watt. Phase 1 pertained to a period of significant planning and preparation. Phase 2 was conducted in a staged process to maximise learning. Phase 2, group 1, involved reviewing the clinical records of a group of 29 deceased patients whose relatives had raised concerns about the care provided by Dr Watt. Phase 2, group 2, involved reviewing the clinical records of 16 patients who had been selected for review as they were due to be seen as part of the recall but sadly died before this could happen.

Phase 3 (this report) involved a review of the clinical records of a further 18 patients, all deceased. Following a public announcement, in each case, the patient's family approached the RQIA to confirm that they wished to proceed with an expert review of their relative's clinical records.

The RCP and the Association of British Neurologists (ABN) agreed that a review under the auspices of the invited review service would be appropriate.

3.1 Terms of reference for this clinical record review

The terms of reference are contained in Appendix 1.

3.2 Approach to this review

The ABN nominated specialist reviewers, enabling the RCP to convene a review team, as set out in Section 3.3.

The RCP was provided with clinical records for 18 patients, as detailed in the terms of reference. Each of the 18 cases was considered independently by two specialist clinical reviewers. Each reviewer used a structured form adapted from the RCP National Mortality Case Record Review (NMCRR) programme[1] to independently examine phases of care that the patient received. These were graded by the reviewers as **1 = very poor care; 2 = poor care; 3 = adequate care; 4 = good care, or 5 = excellent care**. The reviewers also utilised a grading system[2] developed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD)[3] to give an overall perspective on the quality of care provided. This considers both clinical and organisational care. The overall gradings were as follows: **good practice; room for improvement – clinical; room for improvement – organisational; room for improvement – clinical and organisational; unsatisfactory insufficient information**.

Having independently reviewed the cases, the reviewers presented them at virtual meetings on 28 and 29 January and 3 February 2025. The meetings were chaired by the medical director for invited reviews and supported by the RCP review manager, who has extensive experience as a lay reviewer. Each case was considered in turn, the specialist reviewers presented their views, followed by a 'confirm and

challenge' discussion to agree the provisional grading of phases of care and the overall care. In each case, once a provisional grading was agreed, the review team considered a statement from the relatives of the patient and discussed how this information impacted on their assessment of the case. In making judgements about the overall care provided to the patient, the review team considered national good practice and guidelines.

On 3, 4, 20 and 21 March 2025 the review team met with the relatives of 15 of the 18 patients to hear from them directly about their experiences and those of their deceased relative. This helped to ensure that the review team could fully understand all aspects of the case.

The findings contained in this report are outlined in section 4 and represent a summary of the information gathered by the review team during the record review and in discussion with the relatives of the patients. The findings are organised under the headings of the agreed terms of reference. The recommendations were made considering the review team's conclusions.

3.3 Invited review team

Role
Medical director and chair of invited reviews
Consultant neurologist, Scotland
Consultant neurologist, Scotland
Consultant neurologist, Scotland
Lay reviewer

4 Findings

4.1 Clinical record review

The review team's overall ratings for the quality of care provided in the 18 cases were as follows:

Clinical reviewer's overall perspective on quality of care	
Good practice: a standard you would accept from yourself, your trainees (now called resident doctors) and your institution.	RCPxxxx RCPxxxx
Room for improvement: aspects of clinical care that could have been better.	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx
Room for improvement: aspects of organisational care that could have been better.	
Room for improvement: aspects of both clinical and organisational care that could have been better.	RCPxxxx RCPxxxx
Unsatisfactory: Several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.	RCPxxxx RCPxxxx RCPxxxx RCPxxxx
Insufficient information available to assess quality of care.	

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Insufficient evidence
Admission and initial management		RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx		
Clinical decision making		RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx		
Follow-up arrangements		RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx		

			RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx			
Communication with colleagues		RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx			RCPxxxx
Interactions with patients and families		RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx			
Clinical record keeping	RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx			

End-of-life care was not graded as Dr Watt had no clear involvement in the patient's end-of-life care. The review team observed some good practice in terms of end-of-life care, including timely involvement of palliative care (eg RCPxxxx) and the local hospice team (eg RCPxxxx).

	Yes	No	N/A
Was the diagnosis secure?	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx	RCPxxxx
Was Dr Watt's prescribing in keeping with standards expected at the time of the consultation?	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	
Could the cause of death be identified?	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx		
Were there any concerns with the recorded cause of death?	RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	
Should the RQIA refer the case to a coroner for coronial investigation or to request a change to the death certificate?	RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	

	No harm	Low harm	Moderate harm	Severe harm
Did the care and treatment provided to this patient by Dr Watt result in potential harm?	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx RCPxxxx	RCPxxxx

i. Good practice

Two of the 18 cases were graded as good practice for the overall quality of care:

- **RCPxxxx** was graded as good practice overall because the patient's initial admission to hospital, diagnosis of seizures secondary to arteriovenous malformation,[15] and treatment initiated by Dr Watt was considered good care. The review team considered the diagnosis to have been secure and Dr Watt's prescribing was in keeping with standards expected at that time. All other phases of care were graded as adequate, except for interactions with the patient and family (for details see section 4.1.6), and the review team did not identify any harm arising from the care and treatment provided to this patient.

- **RCPxxxx** was graded as good practice overall because the diagnosis of Parkinson's disease in this patient was considered secure, Dr Watt's prescribing was in keeping with expectations at that time and no harm was identified. Follow-up arrangements were graded as good care, and other phases of care were graded as adequate care, except for Dr Watt's clinical record keeping, which was poor care (reflecting the brevity of his letters).

ii. Room for improvement

Of the 18 cases, 11 were graded to show room for improvement for the overall quality of care. Of these 11 cases, nine were graded as room for improvement for clinical reasons (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**), and two were graded as room for improvement for both clinical and organisational reasons (**RCPxxxx**, **RCPxxxx**).

Themes arising from cases where aspects of clinical care could be improved were as follows:

- The diagnosis was considered secure in all the cases graded as room for improvement.

- Dr Watt's prescribing was not in keeping with standards expected at the time in six of the 11 cases graded to show room for improvement (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**). For details see section 4.1.9.

- In two of the cases graded as room for improvement there was concern regarding the recorded cause of death (**RCPxxxx**, **RCPxxxx**). For details see section 4.1.10.

- The care and treatment provided to the patient by Dr Watt was not thought to have led to any potential harm (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**), or the review team identified low harm (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**). In one case graded as room for improvement, there was thought to be potential for moderate harm (**RCPxxxx**) and one was thought to have the potential for severe harm (**RCPxxxx**). For details see section 4.1.11.

- Follow-up arrangements tended to be of appropriate frequency.

- Interactions with patients and families were graded as poor care in eight cases that were found overall to show room for improvement. For details see section 4.1.6.

[15] www.leedsth.nhs.uk/patients/resources/arteriovenous-malformations-avm-and-their-treatment

- Dr Watt's clinical record keeping was graded as poor care in seven cases that were graded to show room for improvement (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**). For details see section 4.1.7.

Themes arising from cases where aspects of organisational care could be improved were as follows:

- It was unclear what provision the trust had for patients diagnosed with MND. Since 1990, the MND Association has developed MND care centres and networks across England, Wales and Northern Ireland, including one based in the Royal Victoria Hospital in Belfast.[16] It is not known when this clinic was established in Belfast, but the family statement relating to **RCPxxxx** indicated a vacuum in terms of services that could offer support to the patient and family. There was an MND coordinator, but no reference was made to a dedicated MND clinic, and the family reported that there was no referral or signposting to other services that might have supported them.

- The review team expected to see the involvement of an epilepsy nurse specialist, particularly in a patient diagnosed with epilepsy who lived alone and had significant cardiological issues (**RCPxxxx**).

iii. Unsatisfactory

Five cases were graded as unsatisfactory in terms of the overall quality of care (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**). This indicated that several aspects of clinical and/or organisational care were well below the review team's expectations.

Themes arising from cases graded as unsatisfactory were as follows:

- Initial management of the patient was graded as poor care in four of the five cases (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**). For details see section 4.1.1.

- Clinical decision making was graded as poor care in all five cases that were graded as unsatisfactory. For details see section 4.1.2.

- The diagnosis was considered not to be secure in three of the five cases graded as unsatisfactory (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**). For details see section 4.1.8.

- Dr Watt's prescribing was not in keeping with standards expected at that time in all five cases graded as unsatisfactory. For details see section 4.1.9.

- Follow-up arrangements were mostly adequate; however, follow-up was graded as poor care in one case. For details see section 4.1.3.

- Interactions with patients and families were graded as poor care in all five cases graded as unsatisfactory. For details see section 4.1.6.

[16] www.mndassociation.org/support-and-information/our-services/care-centres-and-networks/northern-ireland

- Clinical record keeping was graded as poor care and in one case, very poor care, in cases graded as unsatisfactory. For details see section 4.1.7.

- The care and treatment provided to the patient by Dr Watt was thought, potentially, to have led to moderate harm in all five cases graded as unsatisfactory. For details see section 4.1.11.

4.1.1 Initial management

The review team considered initial management of the patient, including history taking, investigations and assessment.

This phase of care was most likely to be graded as demonstrating an acceptable standard of care. Across the 18 cases reviewed, four cases were graded as good care, eight were graded as adequate care, and six were graded as poor care.

The gradings of poor care reflected the review team's observations as follows:

- There was a lack of documented examination of the patient (**RCPxxxx**, **RCPxxxx**).
- Opportunities were missed to request investigations to establish the suspected diagnosis (**RCPxxxx**) or to explore differential diagnoses (other possible explanations for the symptoms) (**RCPxxxx**).
- It was not evident that Dr Watt made a referral for a cognitive assessment despite the original referral highlighting cognitive symptoms and the patient voicing concern about this (**RCPxxxx**).
- Dr Watt's initial clinic letter did not document the type of seizure that the patient was having or detail attempts to obtain a witness account of these events (to establish whether they were epileptic or non-epileptic) or refer to a hospital discharge letter commenting that the patient had some seizures on the ward that were 'atypical' (**RCPxxxx**).
- Dr Watt's initial clinic letter was brief, did not provide an explanation about how he came to a diagnosis of secondary progressive MS and did not describe performing any tests to exclude MS mimics, or blood tests, or a lumbar puncture (**RCPxxxx**).

4.1.2 Clinical decision making

The review team considered clinical decision making, including case selection, evidence-based treatment, MDT discussion, prescribing, and decisions regarding the patient's treatment plan and implementation of this.

This phase of care was most likely to be graded as adequate or poor care. Across the 18 cases, one case was graded as good care under this heading, eight were graded as adequate care, and nine were graded as poor care.

The gradings of poor care reflected the review team's observations that there were shortcomings in Dr Watt's clinical decision making relating to three patients with MS:

- Dr Watt did not request 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. Dr Watt also failed to be clear about when a patient with relapsing and remitting MS entered a progressive phase of the disease (**RCPxxxx**).

- When the condition of another patient with MS deteriorated rapidly, Dr Watt did not document any examination or evidence to exclude an infective component or repeat an MRI scan of the brain or spine (**RCPxxxx**).
- Similarly, there was no clear documentation of infection screening prior to initiating steroids for reported relapses in a different patient with MS, as there should have been as infection can often trigger a relapse. There was little documented examination performed at clinic appointments, making it difficult to ascertain whether this patient had developed secondary progression of the condition. Dr Watt did not request MRI spine imaging, which would have been expected (**RCPxxxx**).

Shortcomings were also identified in Dr Watt's management of some patients who were having seizure-like events:

- Dr Watt's clinic letters failed to describe the type of seizures a patient was having. The review team believe that Dr Watt should have considered undertaking further brain wave testing or referral for video telemetry[17] (electroencephalogram or EEG)[18] as part of an ongoing review of the epilepsy diagnosis in a patient who lived alone and where many suspected seizures were unwitnessed (**RCPxxxx**).
- In another case, an EEG captured an event with no evidence of epilepsy, which should have prompted Dr Watt to review the diagnosis and refer for video telemetry. It was not until 6 months later, after further hospital admissions, that Dr Watt diagnosed non-epileptic attack disorder, although his clinic letters continued to refer to the patient's 'seizures' (**RCPxxxx**).

In several cases, Dr Watt appeared slow to revisit a diagnosis:

- This included revisiting a diagnosis of epilepsy in response to EEG findings suggesting non-epileptic attacks (**RCPxxxx**).
- Another example was failing to revisit a diagnosis of MND made in 2002 when nerve conduction studies and other investigations were not supportive of this diagnosis, and only considering an alternative diagnosis in 2006 when it was observed that the disease was not progressing as would be expected. There was no documented examination of the patient during the intervening 4 years, including checking the patient's reflexes (**RCPxxxx**).
- Dr Watt was also slow to revisit a diagnosis of Parkinson's disease made in 2011 when the patient showed symptoms that did not align with this diagnosis. The GP referral highlighted cognitive symptoms, the patient voiced concern about cognitive symptoms, and subsequent reviews provided further indications that it was more than just Parkinson's disease. It was not until 2014 that Dr Watt documented a degree of dementia. The patient's progressive cognitive decline should have raised concerns, and a formal cognitive assessment should have been undertaken, which was likely to have led to revision of the diagnosis (**RCPxxxx**).
- In case **RCPxxxx**, the review team was unclear how Dr Watt reached a suspected diagnosis of chronic demyelinating neuropathy, since the clinical picture and investigations (nerve conduction studies and an MRI scan) did not clearly support this diagnosis and he failed to arrange a lumbar puncture, which would have helped to establish whether the diagnosis was valid. Dr Watt took a direction that was not supported by the tests he had requested, and his treatment decisions followed from this.

[17] Telemetry is a test that looks at the function of the brain.
[18] A recording of brain activity www.nhs.uk/conditions/electroencephalogram

In some cases, the reason for grading clinical decision making as poor care reflected Dr Watt's prescribing decisions – covered in detail at section 5.1.9.

4.1.3 Follow-up arrangements

The review team considered follow-up arrangements made to review the patient, and the advice provided during these appointments.

This phase of care was most likely to be graded as demonstrating an acceptable standard of care. Across the 18 cases, five cases were graded as good care under this heading, 12 were graded as adequate care, and one was graded as poor care.

The single grading of poor care reflected that Dr Watt should have reviewed a patient's diagnosis of MND much earlier, when it was observed that the patient's condition was not progressing as would be expected (**RCPxxxx**).

4.1.4 End-of-life care

The review team considered end-of-life care.

This phase of care was not graded as Dr Watt was not involved in the patient's end-of-life care. However, a recurring theme from the family statements, which was reinforced in the interviews with family members, was that several families were unprepared for the patient's decline and opportunities were missed to plan for the end of life. There appeared to be a lack of anticipatory care planning in patients with a progressive condition, including such issues as when to prepare for end of life, resuscitation status, power of attorney and capacity assessment.

4.1.5 Communication with colleagues

The review team considered evidence of communication with colleagues, including delegation, referrals and MDT working.

This phase of care was most likely to be graded as demonstrating an adequate standard of care. Across the 18 cases, 11 were graded as adequate care under this heading and six were graded as poor care. There was insufficient evidence to grade one case. None were graded as good care.

The gradings of poor care reflected the review team's observations that:

- It was not evident that Dr Watt clinic letters were copied to cardiology colleagues despite the patient's complex cardiology condition. There was a lack of advice given to the patient's GP regarding signs to be alert to and when to seek further specialist input. The review team expected to see the involvement of an epilepsy nurse specialist, particularly as the patient lived alone (**RCPxxxx**).
- There was no evidence that Dr Watt referred the patient to occupational therapy, physiotherapy and the social work department, despite a decline in mobility and falls. The patient fractured her arm from a fall and early referral to physiotherapy potentially may have avoided this fracture (**RCPxxxx**).
- There was a lack of evidence of MDT input into this patient's care, where the diagnosis of MND was not secure, and a second opinion was needed much sooner (**RCPxxxx**).

- There was often a lack of evidence that Dr Watt made onward referrals for the patient, where this would have been expected. This included to an ear, nose and throat (ENT) specialist or respiratory specialist for a patient presenting with vocal cord spasms and difficulty breathing (**RCPxxxx**). It was not evident that Dr Watt referred a patient whose MS entered the progressive phase to physiotherapy, occupational therapy or for psychological support (**RCPxxxx**). In another case, there was no documented referral to physiotherapy, occupational therapy or speech and language therapy, even after the patient reported falling. This patient went on to suffer two falls that led to hip fractures (**RCPxxxx**).

4.1.6 Interactions with patients and families

The review team considered evidence of interactions with patients and families, including information sharing, discussion and agreement of management plans, duty of candour (where relevant) and copying clinic letters to patients.

This phase of care was most likely to be graded as poor care. Across the 18 cases, four cases were graded as adequate care under this heading and 14 were graded as poor care. None were graded as good care.

The gradings of poor care reflected the review team's observations that:

- There was little documented discussion by Dr Watt with the patient or family members, including with respect to sharing information about the diagnosis, medicines and side effects (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**).
- In case **RCPxxxx**, a lack of communication and supportive care left some family members feeling unprepared for the progression of the disease.
- In case **RCPxxxx**, there was a lack of documented discussion with the patient and family members over a significant change in diagnosis, from a terminal illness (MND) to one that was potentially treatable.
- In case **RCPxxxx**, having raised the possibility of Lewy body dementia,[19] family members felt that their concerns regarding the patient's diagnosis (of Parkinson's disease) were 'batted away' by Dr Watt, only to be told much later that it was Lewy body dementia. Dr Watt was perceived as reluctant to discuss the diagnosis and prognosis.
- In case **RCPxxxx**, Parkinson's disease and the presence of Parkinson's medications can increase the risk of psychosis, which this patient experienced. It was not evident that this was explained to the patient and family, who could have been prepared for signs to watch for.
- In case **RCPxxxx**, there was a lack of documented discussion regarding the risks associated with prescribed treatments, including the risks of steroid treatment in a patient with diabetes.
- There was a lack of evidence to show that patients with notifiable conditions were given advice regarding driving and the need to inform the DVLA[20,21] (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**). Some of these patients went on to experience car accidents (**RCPxxxx**, **RCPxxxx**).

[19] Dementia with Lewy bodies (DLB), also known as Lewy body dementia, is one of the most common types of dementia. It shares some symptoms with Parkinson's disease. www.nhs.uk/conditions/dementia-with-lewy-bodies See also: https://www.parkinsons.org.uk/information-and-support/types-parkinsons

[20] www.gov.uk/driving-medical-conditions

[21] www.gov.uk/parkinsons-disease-and-driving

4.1.7 Clinical record keeping

The review team made observations on the quality of clinical record keeping, including the level of detail in letters and notes of conversations, the use of bundles, and the user friendliness of the records.

This phase of care was most likely to be graded as poor care. Across the 18 cases, five cases were graded as adequate care under this heading, 12 were graded as poor care, and one case was graded as very poor care. No cases were graded as good care.

The gradings of poor care reflected in the review team's observations that:

- Dr Watt's clinical letters were brief and lacked sufficient detail, including failing to specify the diagnosis and prognosis, or documenting discussion with the patient and family members (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**).
- Clinical letters often lacked important details regarding the patient's motor and non-motor symptoms, such as cognition, bladder or bowel symptoms, mood, sleep, speech or swallowing (**RCPxxxx**, **RCPxxxx**).
- Dr Watt did not clearly document neurological examination, including in situations where the diagnosis was uncertain (**RCPxxxx**). Often, he included in letters the phrase 'on examination' continuing that the patient appeared parkinsonian or did not have abnormalities, without detailing what the examination involved (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**).
- Dr Watt did not document discussion with the patient regarding their social history or home living circumstances in cases where this background was important to understanding the patient's support needs (**RCPxxxx**).
- Dr Watt tended not to list all the prescribed medications a patient was taking (**RCPxxxx**, **RCPxxxx**), or document the risks of medications (**RCPxxxx**, **RCPxxxx**), including impulse control behaviour disorder related to use of dopamine agonists (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**).
- 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, including other neurologists (**RCPxxxx**, **RCPxxxx**), cardiologists and a Parkinson's nurse specialist (**RCPxxxx**), and doctors in training (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**, **RCPxxxx**).

4.1.8 Whether the diagnosis was secure

The review team concluded that the diagnosis was secure in most cases – 14 of the 18 cases. The diagnosis was not secure in three cases. In the final case (**RCPxxxx**), no neurological diagnosis was made and so this question was not relevant.

- In case **RCPxxxx**, Dr Watt misdiagnosed MND, in the absence of documented examination of the patient, or to indicate that there may be uncertainty over the diagnosis or that other possible diagnoses had been considered. Dr Watt then considered a second diagnosis (multifocal motor neuropathy), which the review team thought was reasonable, except Dr Watt proceeded to start invasive treatment before obtaining objective evidence that the patient had the condition (such as repeat nerve and muscle tests). The patient was later reviewed by two different neurologists who made the correct diagnosis (posterior interosseous nerve compression / neuropathy) following single consultations.

- In case **RCPxxxx**, Dr Watt believed cognitive symptoms indicated undertreatment of Parkinson's disease and was slow to recognise that the patient's progressive cognitive decline was an

indication that Parkinson's disease was not the correct diagnosis. The review team believed the history and timeline of the patient's decline would suggest Lewy body dementia as a single diagnosis. Clinical records towards the end of the patient's life gave the diagnosis as Lewy body dementia and this was confirmed on autopsy. However, Dr Watt did not refer to a diagnosis of Lewy body dementia in the clinical records seen by the review team.

- In case **RCPxxxx**, Dr Watt's letters failed to specify his suspected diagnosis (CIDP) to the patient's GP; the diagnosis was communicated in discharge letters and in a letter from a doctor in training. It was unclear to the review team how Dr Watt reached the diagnosis of demyelinating neuropathy, as this diagnosis was not supported by the clinical picture or nerve conduction studies, and therefore the treatments the patient received were not indicated. The review team considered the diagnosis was more likely to be a severe diabetic neuropathy[22] and would have expected the patient to have been passed to a peripheral nerve team for treatment.

4.1.9 Prescribing standards

The review team concluded that Dr Watt's prescribing was in keeping with standards expected at the time in seven cases. Concerns were raised regarding the standard of prescribing in the remaining 11 cases, reflecting the following themes.

Lack of discussion regarding side effects:

- A recurring theme was that Dr Watt did not document discussion with the patient regarding the side effects of medications. This included dopamine agonists[23] and side effects such as impulse control disorders or the risk of retroperitoneal fibrosis and cardiac valvular abnormalities (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**), as well as medications for tremor with known side effects in terms of memory problems (**RCPxxxx**). Some patients suffered side effects that may have been related to the medicines they were prescribed. For example, in case **RCPxxxx**, Dr Watt prescribed a dopamine agonist without documenting having explained to the patient and family members the serious neuropsychiatric side effects associated with it, specifically impulse control disorder (including gambling), confusion and hallucinations.[24] The patient went on to develop issues with gambling, hallucinations and paranoia. Dr Watt did not document how he was monitoring the patient for signs of these side effects or document any enquiry into the impact of a higher dose of dopamine agonist in relation to gambling. He later increased the dose further, despite having documented that gambling and hallucinations were present.

- Dr Watt prescribed an off-label treatment (ie not used as described in the leaflet accompanying the medication) without documenting any discussion with the patient about its off-label use or the potential side effects (**RCPxxxx**).

[22] Diabetic neuropathy is when diabetes causes damage to the nerves. It can affect different types of nerves, including in the feet, organs and muscles. www.diabetes.org.uk/about-diabetes/complications/nerves-neuropathy
[23] Dopamine agonists are a class of medication that help stimulate the brain's dopamine receptors, 'tricking' it into thinking it is receiving dopamine. www.parkinson.org/living-with-parkinsons/treatment/prescription-medications/dopamine-antagonists
[24] www.nhs.uk/medicines/ropinirole

- Dr Watt documented that the patient could continue to drive on anti-seizure medication, but did not record any discussion about driving in the context of MS or the fact that this is a notifiable condition to the DVLA[25] (**RCPxxxx**).

Unexplained prescribing decisions:

- Other concerns related to some prescribing decisions, such as some treatments for fatigue (including aspirin, B12 and modafinil), which do not have a good evidence-base for this type of use (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**).

- Dr Watt failed to provide any documented rationale for certain treatments or prescriptions (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**).

- Dr Watt prescribed treatments that were not indicated because the diagnosis he was seeking to treat was not supported by the clinical picture or investigations, and some of the treatments he prescribed carried the potential for harm (**RCPxxxx**).

- Dr Watt prescribed anti-seizure medications for episodes that the review team did not believe were suggestive of seizures (without undertaking detailed assessment and further investigations), using an incorrect starting dose (**RCPxxxx**).

- Dr Watt demonstrated poor management of a patient's hallucinations, which he attributed to higher doses of Parkinson's disease medication; instead of withdrawing this medication, he reduced it and introduced an additional medicine (**RCPxxxx**).

Use of steroids:

- The review team identified situations in which Dr Watt prescribed steroids without documenting any attempt to exclude infection as a cause for the patient's worsening symptoms, or documenting discussion with the patient regarding the risks of steroids (**RCPxxxx**, **RCPxxxx**, **RCPxxxx**), or on the need for monitoring the impact of steroids in a patient with diabetes (**RCPxxxx**).

- Dr Watt often treated patients with MS with steroids. However, sometimes he did not clearly describe the patient's relapses, so it was unclear whether the treatment was appropriate. There was also no documentation of infection screening prior to initiating steroids for reported relapses as there should have been, as infection can offer trigger an MS relapse (**RCPxxxx**).

- In case **RCPxxxx**, Dr Watt prescribed high dose steroids in a patient whose MS had moved into a progressive phase in the absence of any clear description of relapse, and he prescribed a medical cannabis without being clear which symptoms this was specifically to treat.

[25] www.gov.uk/multiple-sclerosis-and-driving

Unclear ongoing monitoring:

- Dr Watt made no reference to blood monitoring when prescribing the disease-modifying medication beta interferon (**RCPxxxx**) or monitoring the impact of dopamine agonists in terms of side effects, such as on renal function (**RCPxxxx**, **RCPxxxx**).

Lack of medicines reconciliation:

- Many patients were on multiple medications, and Dr Watt often changed medication frequently to try to alleviate the patient's symptoms. Sometimes there was a rapid escalation in medication dosage and swift medicine changes (**RCPxxxx**). There was no medicines reconciliation at the start of letters to provide an overview of the medicines the patient was taking (**RCPxxxx**). In case **RCPxxxx**, Dr Watt diagnosed non-epileptic attack disorder and gave advice to withdraw anti-epileptic medications; one was withdrawn, but the patient continued to take another anti-epileptic medication for 14 years.

4.1.10 Cause of death and death certification

Death certificates were provided with the records for the 18 cases and the cause of death could be identified.

The review team had concerns regarding the recorded cause of death in two cases and believed there should be a change to the death certificate to reflect diagnosed medical conditions:

- In case **RCPxxxx**, the death certificate gave the cause of death as: Ia chronic renal failure, Ib ischaemic vascular disease, II pubic ramus fracture,[26] septicaemia. This was also detailed in a coroner record. The review team concluded that the death certificate was not an accurate reflection of the factors underlying the patient's death. First, there was no mention of the patient's Parkinson's disease (this diagnosis was thought to be secure). Second, the family statement raised questions over vascular disease, which the review team could not answer. Third, a renal opinion would be needed on the potential impact of pergolide in the patient's renal failure, and whether the patient had retroperitoneal fibrosis.

  Dr Watt first prescribed pergolide for this patient in August 1998. In March 2003, Dr Watt stated in a letter to the GP that there had been 'considerable problems with renal failure' and pergolide had been replaced with pramipexole. Dr Watt did not document any discussion with the patient regarding pergolide and the risk of retroperitoneal fibrosis, or that this had been raised with him by the renal team. It was not until 2008 that doctors were advised to monitor for potential side effects of ergot dopamine agonists, such as pergolide. However, it appeared that the renal team raised concerns with Dr Watt regarding this prescription in 2003. It was unclear within the medical records whether the patient had obstructive uropathy and renal failure secondary to retroperitoneal fibrosis. No evidence of this was found on a CT scan; however, there appeared to be differing opinions in the notes as to whether the patient had retroperitoneal fibrosis. For these reasons, the review team concluded that this case should be investigated further, including consideration of changes to the death certificate.

26 www.uhd.nhs.uk/uploads/about/docs/our_publications/patient_information_leaflets/orthopaedics/Pubic_rami_fracture.pdf

- In case **RCPxxxx**, the death certificate gave the cause of death as: Ia bronchopneumonia, Ib paraneoplastic syndrome.[27] It did not mention the patient's diagnosis of lymphoma[28] in April 2010, 6 months before the patient's death. The review team believed that 1b should be 'paraneoplastic syndrome secondary to lymphoma'.

4.1.11 Potential harm

Many of the patients included in this review had progressive neurological disorders, 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 were incredibly powerful and brought home just how these diseases had impacted not only the patient but also those around them. In some instances, these experiences appeared to have been exacerbated by some of Dr Watt's interactions with the patient and family members and several families gave accounts of what may be considered to be psychological harm because of the care and treatment provided to their relative by Dr Watt, as detailed under section 1.1.

The review team was asked to consider whether the care and treatment provided to each patient by Dr Watt gave rise to potential harm. Focus was therefore given to determining whether Dr Watt's actions were harmful to patients. The review team was asked to categorise harm to the patient as follows:

- **No harm** – impact prevented, or impact not prevented but no harm occurred
- **Low harm** – minimal (eg patient required extra observation or minor treatment)
- **Moderate harm** – short term (eg patient required further treatment or procedure)
- **Severe harm** – permanent or long-term harm
- **Death** – directly related to care and treatment by Dr Watt

Even though the review team heard of instances where Dr Watt was abrupt or unhelpful, and identified issues around his prescribing of certain medications and some clinical decision making, the potential harm identified by the review team was mostly low or moderate. In six cases, no harm was identified. There was thought to be the potential for low harm in five cases, moderate harm in six cases and severe harm in one case. There was no instance where the review team considered the patient's death was caused directly by the actions of Dr Watt.

Examples of potential low harm:

- A lack of documented referral to physiotherapy, occupational therapy or speech and language therapy in patients who reported falling. One was diagnosed with MND and went on to sustain a spinal fracture (**RCPxxxx**). Another was diagnosed with Parkinson's disease and went on to suffer two falls that led to hip fractures (**RCPxxxx**). Timely involvement of therapy staff may have helped to prevent these injuries.
- Psychological harm, with family members left feeling unsupported and isolated in trying to secure care for the patient, with a lack of signposting to support services (**RCPxxxx**).

[27] Paraneoplastic syndromes are rare disorders triggered by the body's response to cancer.
[28] Lymphoma is a type of blood cancer that affects the immune system. www.bloodcancer.org.uk/understanding-blood-cancer/lymphoma

- A lack of anticipatory planning in a patient with MND, which left family members without a clear plan and exacerbated the distress caused by the disease itself (**RCPxxxx**).
- Psychological harm to a patient given anti-seizure medication and later diagnosed as having non-epileptic seizures, who worried about leaving the house and having a fit, against a background history of mental health issues (**RCPxxxx**).
- Potential physical harm from taking sodium valproate[29] when this was not needed (**RCPxxxx**).
- A failure by Dr Watt to withdraw medications that were not benefitting the patient and were causing side effects (**RCPxxxx**).
- A lack of documented communication by Dr Watt with the patient's family, resulting in their uncertainty regarding the patient's diagnosis of lymphoma (**RCPxxxx**).

Examples of potential moderate harm:

- A lack of timely physiotherapy referral for a patient who went on to have falls and fractured one arm, together with the prescribing of certain medications without clearly documenting discussion with the patient regarding side effects (**RCPxxxx**).
- A lack of coherent multidisciplinary team working, which left the patient and family members feeling abandoned (**RCPxxxx**), lacking supportive care and unprepared for the progression of the disease (**RCPxxxx**).
- The psychological impact of a misdiagnosis of a terminal illness, which left one patient believing he had only a short time to live and led to opportunities missed to address the patient's underlying condition (**RCPxxxx**).
- The psychological harm of misdiagnosis for a patient and their family members, and alleged dismissal by Dr Watt of the possibility of what turned out to be the correct diagnosis (**RCPxxxx**).
- Prescribing medications that were likely to have exacerbated psychotic episodes (**RCPxxxx**, **RCPxxxx**) and had other impacts, such as loss of life savings through gambling (**RCPxxxx**) and potential mood-related harm (**RCPxxxx**).
- Unnecessary treatment, which did not help to resolve the patient's symptoms and needlessly exposed him to risks (**RCPxxxx**).
- A lack of documented evidence of driving advice given to a patient who went on to crash his car while his wife was a passenger (**RCPxxxx**).

[29] Sodium valproate is used to treat epilepsy, as well as some other conditions. www.nhs.uk/medicines/sodium-valproate

One case of potential severe harm:

- In case **RCPxxxx**, the review team concluded that the potential for harm was severe, as there was no evidence that Dr Watt planned to monitor the patient while the patient was taking pergolide (see section 4.1.10 for details about this medicine and a potential side effect in terms of renal failure; further details are also provided in the full case summary), aside from standard follow-up appointments. This created the potential for unsupervised renal deterioration. It was reasonable to prescribe pergolide, but it required supervision and communication with the renal team. The lack of monitoring by Dr Watt, and the failure to relay in his letter of March 2003 the reasons 'why' pergolide had been stopped, led the review team to grade this case to show room for improvement for clinical reasons. The review team highlighted the potential for severe harm in this case. Specialist renal input may be required to establish whether actual harm occurred.

5 References

1 National Mortality Case Record Review Programme www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme [Accessed 26 January 2022].
2 National Confidential Enquiry into Patient Outcome and Death: grading system for use by case reviewers www.ncepod.org.uk/grading.html [Accessed 26 January 2022].
3 National Confidential Enquiry into Patient Outcome and Death www.ncepod.org.uk [Accessed 26 January 2022].

6 Appendices

6.1 Appendix 1: Terms of reference

Regulation and Quality Improvement Authority

Final terms of reference

1. Background

On 1 May 2018, the Belfast Health and Social Care Trust ('the trust') announced a recall of approximately 2,500 patients who had been under the care of Dr Watt, a consultant neurologist, following concerns regarding his clinical management. The recall was instigated following the trust's internal review process and subsequent request to the Royal College of Physicians (RCP) to review a series of patients who had been under the care of Dr Watt. The trust's review culminated in Dr Watt ceasing all patient care and treatment in the summer of 2017. It is noted that patients who had seen Dr Watt privately were also included as part of the recall.

In May 2018, the permanent secretary in Northern Ireland requested that the Regulation and Quality Improvement Authority (RQIA) conduct an expert review of clinical records of all patients or former patients of Dr Watt in the preceding 10 years. A formal direction of this was also issued by the chief medical officer on 10 May 2018. It was determined that the Expert Review of Records of Deceased Patients of Dr Watt would be undertaken in phases. Phase 1 pertained to a period of significant planning and preparation.

The RQIA commissioned the RCP to conduct phase 2 of the Expert Review of Records of Deceased Patients of Dr Watt. Phase 2 was conducted in a staged process to maximise learning. The first stage was to review the clinical records of a group of 29 deceased patients whose relatives had raised concerns about the care provided by Dr Watt. The second phase involved a review of the clinical records of a second group of 16 patients who had been selected for review as they were due to be seen as part of the recall but sadly died before this could happen.

This third phase (phase 3) will involve a review of the clinical records of a further 18 patients. In each case the patient is deceased, and their families have approached the RQIA to confirm that they wish to proceed with an expert review of their relative's clinical records.

The RCP and the Association of British Neurologists agreed that a review under the auspices of the invited review service would be appropriate.

2. Expertise required

- Chair of the review (RCP medical director of invited reviews)
- Consultant neurologist x 3
- Lay reviewer and review manager, RCP

3. Methodology

This review will take place in two stages: an independent review of the clinical records followed by consideration of concerns and issues raised by the families about the care received by their relative. It will be conducted virtually.

In undertaking the review, the review team will consider whether the care provided aligns with national good practice and guidelines, and/or with what a body of clinical professionals might consider appropriate in a similar situation.

Stage 1 (to be completed prior to stage 2)
The RCP will provide an independent and expert review of 18 former patients of Dr Watt using a structured judgement review (SJR) tool and assess the overall quality of neurology care provided to those patients by Dr Watt.

Stage 2

While stage 1 is progressing, the RQIA will liaise with the families and carers of the patients to discuss whether they wish to share any particular issues or concerns with the RCP review team. Those who do will be asked to complete a form requesting details of the key areas of concern (provided separately). Following completion of stage 1, the RCP review team will consider concerns from the families and carers in the form of written statements and will conduct interviews with those who wish to participate in this way.

The review team will highlight any lessons to be learned, recommend appropriate actions (where relevant) and provide an individual case summary for each patient reviewed.

4. Issues to be explored

In reviewing the clinical management of the patients in this group and assessing the overall quality of care provided, consideration will be given to:

- the initial investigations and choice of treatment options
- whether the diagnosis was secure
- whether the ongoing management and treatment of the patient was appropriate
- whether the prescribing was appropriate
- follow-up arrangements in place
- communication with colleagues and MDT working
- communication with the patient and/or their family/carers
- clinical record keeping
- whether there are any concerns about the impact of the care and treatment provided by Dr Watt and which may have resulted in potential patient harm
- where the clinical records indicate a likely cause of death, the RCP reviewers will also provide their considered view. If there is a significant difference of opinion, this information may subsequently prompt the RQIA to refer the case to a medical examiner or coroner for further review.

5. Reporting

The review team will prepare a report that makes recommendations, as relevant, for the consideration of the requesting healthcare organisation. Once issued, the final report becomes their property.

The RCP will recommend that the final report is shared with the Department of Health and other relevant external stakeholders.

6. Date of agreement

The above terms of reference were agreed by the Royal College of Physicians and the Regulation and Quality Improvement Authority on 9 August 2024.

6.2 Appendix 2: Structured judgement tool

Structured judgement review form – multiple cases

RCP number:	
Initials of patient and hospital reference no:	
Case description:	
Initials of reviewer:	

1. Background/summary of the relevant patient's history *Brief clinical history eg gender, age, co-morbidities, presenting condition, any operations, other relevant factual information. Make a note of key dates (bullet point if helpful)*
Click here to enter text.

2. Admission and initial management *History taking, investigations and assessment*	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

3. Clinical decision making *Case selection, evidence-based treatment, MDT discussion, prescribing, decisions regarding treatment plan and implementation of this*	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

4. Follow up arrangements *Details of follow up arrangements in place, advice given etc*

Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

5. End of life care *Involvement of palliative care, as appropriate*	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

6. Communication with colleagues *Evidence of communication with colleagues including delegation, referrals, MDT working*	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

7. Interactions with patients and families *Sharing of information, discussion and agreement on management plans, duty of candour (if applicable), copying clinic letters to patients etc*	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):** ☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

8. Clinical record keeping *Observations on quality of record keeping, level of detail in letters and notes of conversations, use of bundles, user friendliness*	
Click here to enter text.	**Please grade this phase of care (mark with an 'x'):**

	☐ 1 = very poor care ☐ 2 = poor care ☐ 3 = adequate care ☐ 4 = good care ☐ 5 = excellent care

Questions specific to this review

9. In your opinion, was the diagnosis secure?

☐ Yes
☐ No

Please provide a reason for your answer:

10. Was Dr W's prescribing in keeping with standards expected at the time of the consultation?

☐ Yes
☐ No

Please provide a reason for your answer:

11. Could you identify within the clinical records the certified cause of death?

☐ Yes
Please detail the cause of death and proceed to Q12:

☐ No
(proceed to Q14)

12. Did you have any concern about the certified cause of death?

☐ Yes
Please provide reasons for your answer and proceed to Q13:

☐ No

(proceed to Q14)

13. Do you think this case should be subject to further scrutiny?

☐ Yes, a referral should be made to the NI coroner's service for coronial investigation

☐ Yes, a referral should be made to the NI coroner's service to request a change to the death certificate

☐ No

14. In your opinion, did the care and treatment provided to this patient by Dr W result in potential harm?

☐ **No harm** – impact prevented, or impact not prevented but no harm occurred
☐ **Low harm** – minimal (eg patient required extra observation or minor treatment)
☐ **Moderate harm** – short term (eg patient required further treatment or procedure)
☐ **Severe harm** – permanent or long-term harm
☐ **Death** – directly related to care and treatment by Dr W

Please provide a reason for your answer:

15. Are there any other issues you wish to raise?

Click here to enter text.

16. Clinical reviewer's overall perspective on quality of care
(please mark x in the relevant box)

☐	**Good practice:** A standard you would accept from yourself, your trainees and your institution.
☐	**Room for improvement:** aspects of clinical care that could have been better.
☐	**Room for improvement:** aspects of organisational care that could have been better.
☐	**Room for improvement:** aspects of both clinical and organisational care that could have been better.
☐	**Unsatisfactory:** several aspects of clinical and/or organisational care that were well below that you would accept from yourself, your trainees and your institution.
☐	**Insufficient information available** to make an assessment of quality of care.

6.3 Appendix 3: Family statement template

Purpose of this form:
This form has been developed to assist the families of the deceased patients whose records have been selected for Phase Three of the Expert Review to share their concerns about the care and treatment their relative received while under the care of Dr Michael Watt, former Consultant Neurologist. By completing this form, you are giving RQIA your permission to share the information you have provided with the expert review panel who will be reviewing your deceased relative's records, to help them better understand your concerns.
How to complete this form:
By completing Sections 1 and 2, you assist RQIA in keeping accurate records of your contact details and connecting you to your deceased relative. These sections will be retained in confidence by RQIA and will not be shared with the expert review panel. **Section 3 provides information about our Duty to Disclose.** **RQIA will complete Section 4.** **Sections 4, 5, 6, & 7 will be shared with the expert reviewer panel.**

Section 1: Please provide your personal details in the boxes below:	
Your Name:	
Address:	
Telephone Number(s):	
Email Address:	
Are you:	☐A relative: If so, please specify relationship: ☐Other: Please specify:

Section 2: Please provide personal details about your deceased relative in the boxes below:	
Name:	
Date of Birth:	
Date of Death:	
Health & Care Number (if known)	

Section 3: Our Duty to Disclose
The information you provide to us is very much appreciated as it will help to inform this Review. Please be assured that RQIA will at all times seek to ensure that no information relating to the data and records of any person is disclosed to any third party unless disclosure is required under the FOI Act, or by law, court or tribunal. Occasions may arise whereby RQIA is required to disclose information in respect of the Review, in the vital interests of other persons or for reasons relating to the health, safety or welfare of other persons, for reasons of public health, for the purposes of any criminal investigation or to the coroner. No such disclosure will occur unless and until the following:

- **The relevant Health & Social Care Body has been informed;**
- **Any legal advice required has been considered; and**
- **Agreement has been reached with regard to the extent of the information required to be disclosed and if necessary, anonymised.**

Section 4: For Office Use Only	
RCP Number:	
Name of Patient:	
Health & Care Number:	

Section 5: Outline any issues or concerns you may have had about the care and/or treatment provided to your loved one by Dr Watt:

Section 6: Describe how the care and treatment provided to your loved one affected their life:

Section 7: What are you hoping will happen as a result of sharing your concerns?

6.4 Appendix 4: Case summaries

This document is provided separately.