Royal College of Physicians

Setting higher standards

Invited Reviews

Report of the clinical record review for

Regulation Quality Improvement Authority on 1–2 December 2025, and 12 and 16 January 2026

This report is the property of the healthcare organisation responsible for the commission of this invited review

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[a] ('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.[b]

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 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 2004–21). RQIA intends to publish the final report.

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[c] 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 is comprised of the same expert consultant neurologists as the Phase 3, group 1 review[d] (section 3.3). The experts scrutinised the clinical records associated with the

[a] www.belfasttrust.hscni.net

[b] www.health-ni.gov.uk/news/independent-neurology-inquiry-implementation-plan-published

[c] Under the terms of reference agreed for this review, there were originally eight patients in this group. It was subsequently established that one patient (identified as RCPxxxx) had never been under the care of Dr Watt and so their case was not included in the review.

seven patient cases and 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 the seven 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 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 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. For details see sections 4.1.1, 4.1.2, 4.1.3 and 4.1.8.

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. For details, see section 4.1.9.

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[e] 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)[f] rather than idiopathic Parkinson's disease. Whereas this patient's cause of sudden death was recorded as myocardial infarction,[g] 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. See section 4.1.10 for details.

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. See section 4.1.5 for details.

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.

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

[f] 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.

[g] 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.

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. See section 4.1.6 for details.

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. For details, see section 4.1.7.

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 (see section 4.1.11 for the definitions of harm that the review team was asked to consider), 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. For details, see section 4.1.11.

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.

1.1 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 2 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[h] had progressive neurological disorders, such as astrocytoma[i] 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[j] had a brainstem infarction (stroke) which resulted in him having significant neurological deficit in the form of 'Locked in syndrome'[k] and saw Dr Watt only for a short period some years later in relation to seizures. The final patient[l] 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

[h] The patients in cases RCPxxxx, RCPXXXX, RCPXXXX, RCPXXXX and RCPXXXX.
[i] Astrocytoma is a type of brain tumour. https://www.macmillan.org.uk/cancer-information-and-support/brain-tumour/astrocytoma.
[j] The patient in case RCPXXXX.
[k] 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. https://www.stroke.org.uk/stroke/effects/physical/locked-in-syndrome
[l] The patient in case RCPXXXX.

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.

2 Recommendations

Key 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. 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: https://www.aomrc.org.uk/wp-content/uploads/2026/04/Please_write_to_me_update_130426.pdf	**Medium term**
b. 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. 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.	**Long term**
c. 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.	**Short term**

3 Background to the review

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 group 1 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.
- Phase 3, group 2 (this review) is the final stage of the expert review of records of deceased patients of Dr Watt. It involved the review of the care provided to a final group of seven patients whose families confirmed while the Phase 3, group 1 review was underway that they wished to proceed with the review of their deceased family member'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 7 patients, as detailed in the terms of reference. Each of the 7 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 the 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, and unsatisfactory insufficient information**.

Having independently reviewed the cases, the reviewers presented them at virtual meetings on 1 and 2 December 2025. The meetings were chaired by the medical director for invited reviews and supported by the RCP review manager. 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 12 and 16 January 2026, the review team met with the relatives of the seven 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

The terms of reference for this review listed a lay reviewer who was intended to join the team for the meetings with families. The lay reviewer was unable to attend these due to ill health.

4 Findings

4.1 Clinical record review

The review team's overall ratings for the quality of care provided in the seven 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.	
Room for improvement: Aspects of clinical care that could have been better.	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 what you would accept from yourself, your trainees and your institution.	RCPXXXX, RCPXXXX, RCPXXXX
Insufficient information available to assess quality of care.	

Of the seven cases, four were graded to show room for improvement for the overall quality of care. Of these four cases, two were graded as room for improvement for clinical reasons (RCPXXXX, RCPXXXX), and two were graded as room for improvement for both clinical and organisational reasons (RCPXXXX, RCPXXXX). The remaining three cases were graded as unsatisfactory overall.

Gradings for each phase of care are provided under the headings below. Of note, in all cases each phase of care was graded as adequate, poor or (in relation to one phase of care in case RCPXXXX) very poor. There were no gradings of good or excellent care.

4.1.1 Initial management

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

	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			

Across the seven cases reviewed, four cases were graded as adequate care and three were graded as poor care.

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

- Opportunities were missed to request investigations to establish the suspected diagnosis in case **RCPXXXX**. When Dr Watt first saw the patient, cerebrovascular[m] causes for his symptoms had already been ruled out. Dr Watt diagnosed focal seizures and prescribed anti-seizure medication. The review team considered that the patient's history and symptoms at that time suggested a differential diagnosis of migraine with sensory aura[n] which was not explored. Dr Watt did not ask the patient about whether he was experiencing loss of awareness or automatisms[o] to help consolidate the diagnosis. No EEG[p] was requested, which could have been done to capture and investigate the events further.
- In case **RCPXXXX,** after initial examination of the patient, Dr Watt recommended pergolide[q] and referred the patient to the Parkinson's disease nurse specialist. The nurse relayed to Dr Watt that the patient did not want to start on the drug at that stage as she considered that her symptoms did not yet warrant this. Dr Watt's response was to ask the nurse to tell the patient that he thought she should start the drug. The review team considered that, while it was not unreasonable to start pergolide at that time, Dr Watt should have respected the patient's concerns about this and discussed it with her directly.
- At Dr Watt's initial consultation there was little evidence of any detailed clinical examination or any documented discussion with the patient about the diagnosis, treatment options or side effects of the medication prescribed, including impulse control disorders (**RCPXXXX**).

Reasons for cases being graded as adequate, rather than good care under this phase included

- A lack of detailed documented examination of the patient (**RCPXXXX**).
- Opportunities were missed to request investigations to explore differential diagnoses (**RCPXXXX**).
- There was a lack of documented discussion (by the doctor in training who completed the initial assessment) about safety in relation to a diagnosis of epilepsy, including whether the patient was a driver and potential side effects of medications prescribed (**RCPXXXX**).

4.1.2 Clinical decision making

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Insufficient evidence
Clinical decision making		RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX	RCPXXXX			

[m] Conditions affecting blood flow to the brain, such as stroke, transient ischemic attack (TIA) or intracranial haemorrhage.
[n] Aura is a term used to describe a neurological symptom of migraine. Sensory aura, which can involve numbness and tingling of the lips and tongue on one side of the face, spreading to involve the cheek and gradually extending to involve the hand on that side of the body.
[o] Involuntary, often repetitive, and semi-purposeful behaviours performed without conscious awareness, typically during or immediately after a seizure or due to other neurological/psychiatric conditions.
[p] A test involving the recording of brain activity. www.nhs.uk/conditions/electroencephalogram
[q] Pergolide is a dopamine-receptor agonist which means that it acts on the same receptors in the brain as dopamine. www.patient.info/medicine/pergolide-for-parkinsons-disease

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 aspect of care was one of those most likely to be graded as poor care. Across the seven cases, one case was graded as adequate care under this heading, while the remaining six cases were graded as poor care.

In some cases, the reason for grading clinical decision making as poor care reflected Dr Watt's prescribing decisions – covered in detail at section 4.1.9. Other concerns under this phase of care in cases graded as poor were as follows.

In two cases, the review team considered that Dr Watt failed to revisit a diagnosis when the patient's symptoms and the trajectory of their condition strongly indicated that this was needed:

- In case **RCPXXXX**, the rapid progression of the patient's condition and some of the symptoms described led the review team to question the security of the original diagnosis of Parkinson's disease (see section 4.1.8 below). The review team considered that alternative causes of the patient's symptoms should have been considered in this case.
- In case **RCPXXXX**, it was repeatedly documented that there had been no improvement in the diagnosed seizures despite multiple medication changes. There were also symptoms reported by the patient during this period which, taken together, the review team considered to be more likely indicative of a different diagnosis. At no point was it evident that the diagnosis had been reviewed, the patient's history re-taken with a witness account or appropriate investigations such as EEG or video telemetry[r] considered or requested.

There was a failure to adequately investigate new or developing symptoms in two cases:

- When the patient reported symptoms that Dr Watt considered 'minor seizures' an EEG would have helped to determine whether the symptoms were actually seizures or whether they may have been the result of having had a tumour and surgery. No EEG was done and Dr Watt prescribed an increased dose of anti-epileptic medication which may not have been necessary (**RCPXXXX**).
- In case **RCPXXXX**, the patient was seen by a consultant neurosurgeon shortly after Dr Watt had documented that he was experiencing frequent minor seizures and increased his medication. The consultant neurosurgeon identified changes in the patient's speech and cognition and a further MRI scan[s] was planned to help determine whether this was caused by the patient's brain tumour or by the anticonvulsant medication. The review team considered that this investigation should have been requested at an earlier stage by Dr Watt. There was also a failure throughout the patient's care under Dr Watt to document a thorough and comprehensive examination of the potential impact of the patient's tumour on his vision.

In case **RCPXXXX**, the review team observed a persistent lack of detailed examination and a lack of discussion with the patient about his condition and treatment options. There was also evidence that Dr

[r] Telemetry is like an electroencephalogram (EEG) test, but it records over a much longer period of time, sometimes taking up to 5 days to get the information needed. Video will also be recorded during the test.

[s] Magnetic resonance imaging – a scan that takes detailed pictures of the inside of the body

Watt failed to promptly address evidence that the patient was undertreated which had the potential to put the patient at risk, especially of falls.

4.1.3 Follow-up arrangements

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Insufficient evidence
Follow-up arrangements			RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX			

The review team considered follow-up arrangements made to review the patient.

This phase of care was most likely to be graded as demonstrating an acceptable standard of care with all cases graded as adequate because Dr Watt's follow-up arrangements were of appropriate frequency, if often poorly documented (see section 4.1.7 below). However, concerns were identified in two cases about the follow-up care provided in 2017 when Dr Watt was on leave, while concerns about his practice were investigated, indicating a failure to ensure appropriate transition of Dr Watt's patients to colleagues in his absence:

- In case **RCPXXXX,** the patient was not provided with adequate neurological care after her stroke in April 2017; and no alternative support was provided when Dr Watt was not available. As a result, the patient's family had to repeatedly request that the patient be reviewed, but no appointment was offered until after the patient's death in December 2017.

- In case **RCPXXXX,** the patient was urgently referred to the neurology service in October 2017 by his GP as he was experiencing side effects from Parkinson's medication including hallucinations. While Dr Watt was on long term sick leave it was noted that the patient had not been seen in the neurology service for over 2 years. The patient's neurological care was under another consultant from this point on.

4.1.4 End-of-life care

In all cases, this phase of care was not graded as Dr Watt was not involved in the patient's end-of-life care. However, there was evidence in some cases that opportunities were missed to engage in advance planning for the end of life (**RCPXXXX, RCPXXXX, RCPXXXX**).

The review team also observed some good practice in terms of end-of-life care provided by palliative care and/or primary care services (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**, **RCPXXXX, RCPXXXX**).

4.1.5 Communication with colleagues

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Insufficient evidence
Communication with colleagues		RCPXXXX RCPXXXX RCPXXXX RCPXXXX	RCPXXXX RCPXXXX RCPXXXX			

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

Across the seven cases, three were graded as adequate care under this heading and four were graded as poor care.

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

- Dr Watt's clinic letters sent to the patient's GP were lacking in detail and provided insufficient guidance (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**).
- there was a lack of MDT input into the patient's care, where this would be expected (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**). In case **RCPXXXX**, there were times when referrals should have been made to colleagues in Physiotherapy, Occupational Therapy and Speech and Language Therapy but this was not done. On one occasion the patient himself had to ask for a referral for occupational therapy support as he was experiencing difficulties getting in and out of bed as well as completing kitchen tasks.
- there was a lack of communication and coordination between professionals involved in the patient's care, with teams appearing to work independently of one another (**RCPXXXX**, **RCPXXXX**). In case **RCPXXXX**, the patient raised with Dr Watt in April 2007 that the MRI brain scan he had in February that year had not been reported. Dr Watt failed to follow this up with colleagues. This was in the context of the patient experiencing poorly controlled seizures and should have been addressed promptly. In July 2007, when the report was still not available, Dr Watt did not contact colleagues to obtain the report and advised the patient that he could make a complaint. When the scan was eventually reported later in July 2007 and there was no previous imaging available to compare it to, Dr Watt again failed to resolve this, simply noting it in a letter to the patient's GP rather than making direct enquiries after the imaging.

4.1.6 Interactions with patients and families

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Insufficient evidence
Interactions with patients and families		RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX				

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.

All cases were graded as poor care under this heading. In all cases, the clinical records reviewed contained very little evidence of interactions with patients and families and clinic letters were not copied to patients. Copying letters to patients is considered good practice.

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

- **in all cases** there was little or no documented discussion by Dr Watt with the patient or family members, including with respect to sharing information about the diagnosis, medicines and side effects. This was a factor in patients' confusion and anxiety around their medication (**RCPXXXX**, **RCPXXXX**) and one patient presented with recognised and significant side effects of topiramate[t] that had not been explained to him prior to commencement of the medication (**RCPXXXX**).
- there was a lack of signposting to other services which could provide support to the patient and their family and enable advanced care planning (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**, **RCPXXXX**).
- there was a lack of evidence to show that patients were given appropriate advice regarding the safety implications of their condition for driving[u] (**RCPXXXX**, **RCPXXXX**).
- in case **RCPXXXX**, Dr Watt's failure to adequately follow up the result of MRI scans (see above) demonstrated a lack of advocacy for the patient.
- as noted above, in case **RCPXXXX** Dr Watt failed to discuss with the patient her concerns about commencing pergolide.
- in both cases **RCPXXXX and RCPXXXX**, the patient's family described Dr Watt providing advice out of hours when the patient/their family contacted him on his personal mobile phone, including changes to medication without any examination of the patient and without access to their records. The review team saw no documentation of this in the records reviewed.

4.1.7 Clinical record keeping

	Very poor care (1)	Poor care (2)	Adequate care (3)	Good care (4)	Excellent care (5)	Insufficient evidence
Clinical record keeping	RCPXXXX	RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX	RCPXXXX			

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

[t] Topiramate is an anti-epileptic medicine. www.nhs.uk/medicines/topiramate/about-topiramate

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

For this phase of care, one case was graded as adequate care, five were graded as poor care and one 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. This included other neurologists, consultants in other specialties, a Parkinson's nurse specialist and doctors in training.

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

- often, Dr Watt did not clearly document neurological examination. At times, he included in letters the phrase 'on examination', continuing that the patient appeared parkinsonian without detailing what the examination involved (**RCPXXXX**, **RCPXXXX**).
- clinical letters were brief and often lacked important details such as the patient's motor and non-motor symptoms (**RCPXXXX**), the patient's driving status (**RCPXXXX**, **RCPXXXX**) or length of time the patient had been seizure-free when resuming driving (**RCPXXXX**), the reasons for the patient's recent attendance to the hospital Emergency Department (**RCPXXXX**), and what change had been made by colleagues in Bristol to a patient's medication (**RCPXXXX**).
- the rationale for changes to medication were often not adequately documented and were unclear to the review team (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**).
- in case **RCPXXXX**, with a number of different specialties involved in the patient's care, clinic letters did not include a diagnostic summary list. The reviewers would expect to see this to ensure that all those involved in the patient's care were clear on their symptoms and treatment. This is a safeguard to prevent prescriptions from different teams resulting in negative drug interactions.

4.1.8 Whether the diagnosis was secure

	Yes	No	N/A
Was the diagnosis secure?	RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX	RCPXXXX RCPXXXX	

The review team concluded that the diagnosis was secure in most cases – five of the seven cases reviewed. The diagnosis was not secure in two cases.

In case **RCPXXXX**, the diagnosis of Parkinson's disease was made by another consultant neurologist and confirmed by Dr Watt on initial assessment of the patient. While the review team considered that the initial diagnosis of Parkinson's disease was reasonable at that stage, the rapid progression of the patient's condition and some of the symptoms described led the review team to question the security of the diagnosis. Specifically, the review team considered that there were other potential explanations for the emergence of falls at a relatively early stage, the patient's discoloured hands, urinary incontinence, camptocormia (a condition where the spine bends forward while standing but straightens when lying down), postural hypotension[v] and marked blood pressure swings. This combination strongly suggests a condition called MSA. While an alternative diagnosis could not be confirmed on the basis of the

[v] A drop in blood pressure when you stand up after lying or sitting down.

information available, the review team was of the view that alternative causes of the patient's symptoms should have been considered, documented and explored in the context of the clinical trajectory recorded.

As discussed above, in case **RCPXXXX** the review team noted that in many outpatient consultations with Dr Watt it was documented that there had been no improvement in the diagnosed seizures despite multiple medication changes. There were also symptoms reported by the patient during this period which, taken together, the review team considered to be more likely indicative of a diagnosis of migraine with sensory aura than of epilepsy. These included right face numbness combined with left limb numbness, pressure sensation and nausea. Dr Watt did not revisit the original diagnosis of epilepsy or undertake any of the further examination and investigation that the review team would expect to see in these circumstances.

4.1.9 Prescribing standards

	Yes	No	N/A
Was Dr Watt's prescribing in keeping with standards expected at the time of the consultation?		RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX	

The review team concluded that in all cases Dr Watt's prescribing was not in keeping with standards expected at the time. Concerns reflected the following themes.

Multiple medications, rapidly titrated[w]:

- A recurring theme observed to varying degrees in **all of the cases reviewed** 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.

Combinations of medications prescribed:

- In case **RCPXXXX**, there was insufficient documented evidence that the risk of interaction between some of the medications prescribed with the patient's chemotherapy treatment was appropriately considered.

Unexplained prescribing decisions:

- The rationale for Dr Watt's prescribing was not clearly documented and/or was not clear to the review team in some cases (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**, **RCPXXXX**). For example:
  - In case **RCPXXXX**, the review team questioned the evidence base for prescribing galantamine[x] to address the patient's falls and considered that this would not have been common practice.
  - In case **RCPXXXX**, the review team questioned Dr Watt's decision to prescribe topiramate as the drug is teratogenic (it can cause structural or functional defects in a developing foetus or

[w] Titration is the process of starting medication safely and gradually, while monitoring how the body responds
[x] A medication used to treat dementia

embryo, leading to birth defects) and the patient was a woman of childbearing age. The review team saw no evidence that this had been discussed with the patient.

> In case **RCPXXXX**, the review team was concerned by Dr Watt's recommendation to re-prescribe ropinirole (which can induce psychosis including hallucinations, delusions and disorganised thoughts) after it had been stopped when the patient experienced a severe episode of psychosis during a hospital admission. Dr Watt did recommend that the drug only be restarted if the patient was not experiencing hallucinations but the review team considered that this remained inappropriate in a patient with past experience of psychosis while on the drug.

Monitoring:

- Monitoring arrangements for medications prescribed were insufficient in case **RCPXXXX** (monitoring of the side effects of sodium valproate),[y] and cases **RCPXXXX** and **RCPXXXX** (monitoring of the risk that chronic use of drugs such as pergolide and cabergoline may damage cardiac function).[z]

Lack of discussion regarding side effects:

- As noted above under section 4.1.6, **in all cases** there was little or no evidence that Dr Watt discussed the side effects of medications prescribed with patients. For example:
  - in case **RCPXXXX**, the review team saw no documented evidence of discussion about the side effects of lamotrigine[aa] or topiramate. When the patient reported mood disturbance, Dr Watt suggested changing replacing topiramate with levetiracetam[bb] with no explanation about side effects including that this drug was also associated with mood disturbance.
  - > as noted above, the review team saw evidence that in case **RCPXXXX** the patient attended a hospital Emergency Department with recognised and significant side effects of topiramate that had not been explained to him prior to commencement of the medication. Moreover, when Dr Watt added lamotrigine to the sodium valproate already prescribed, this was done without any explanation of the synergy of these two medications and the signs of lamotrigine toxicity.[cc]
  - > in case **RCPXXXX**, the patient was prescribed pergolide until it was withdrawn in November 2011. The European Medicines Agency (EMA) published a warning about the increased risk of damage to cardiac function as a result of long term use of pergolide in 2008. The review team considered that it was not unreasonable for some patients to remain on the drug after that time, where its impact was adequately monitored and there

[y] Sodium valproate is used to treat epilepsy. www.nhs.uk/medicines/sodium-valproate

[z] Both drugs are known to increase the risk of damage to cardiac function including valvular heart disease and cardiac fibrosis. Regular echocardiographic monitoring for patients on taking these drugs is therefore recommended.

[aa] Lamotrigine is an anti-epileptic medicine. http://www.nhs.uk/medicines/lamotrigine/about-lamotrigine

[bb] Levetiracetam is an anti-epileptic medicine www.nhs.uk/medicines/levetiracetam/about-levetiracetam

[cc] Lamotrigine toxicity primarily affects the central nervous system and heart, with common symptoms including severe drowsiness, unsteadiness, seizures and a rapid heartbeat. While many overdoses result in mild or no effects, large ingestions can be life-threatening and require immediate medical attention. Combining lamotrigine and sodium valproate significantly increases the risk of lamotrigine toxicity because sodium valproate inhibits the metabolism of lamotrigine, leading to elevated and potentially toxic levels of lamotrigine in the bloodstream.

was an open discussion with the patient about the risks and benefits. However, such discussion was not in evidence in this case.

- in case **RCPXXXX**, there was no documentation of any explanation given to the patient and his family about side effects of his anti-seizure medication. This was particularly concerning in the context of the patient's documented psychological symptoms including depression, anxiety and pseudobulbar affect[dd] which could have been exacerbated by some of the drugs prescribed.

4.1.10 Cause of death and death certification

	Yes	No	N/A
Could the cause of death be identified?	RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX RCPXXXX		
Were there any concerns with the recorded cause of death?	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	

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

The review team had concerns regarding the recorded cause of death in one case, **RCPXXXX**, which was recorded as a myocardial infarction. As noted above, the review team considered that a possible alternative diagnosis in this case was that of MSA. The condition can lead to sudden death due to a combination of factors, including respiratory failure from disordered breathing and upper airway obstruction such as stridor and cardiac autonomic dysfunction.[ee]

The review team concluded that the ambiguity of the diagnosis in this case and the fact that an alternative diagnosis of MSA can be a cause of sudden death raised potential concern about the accuracy of the patient's certified cause of death. That uncertainty could not be resolved on the

[dd] A condition causing sudden, uncontrollable outbursts of laughing or crying, often mismatched with a person's internal feelings

[ee] Impaired control of heart rate, blood pressure and related functions.

information available. The reviewers were also of the view that this matter would not be possible to resolve at this stage by way of further investigation by the Northern Ireland coroner's service.

4.1.11 Potential harm

	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		

The review team was asked to consider whether the care and treatment provided to the patient by Dr Watt gave rise to potential harm. 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

It is important to note that, although in each case the review team determined that the potential clinical harm identified was at the lower end of this scale, that conclusion does 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. It was clear from accounts provided by family members that the already very difficult circumstances of their relative's condition were exacerbated in some cases by 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 by Dr Watt, as detailed under section 1.1.

As set out above, in this cohort of seven patients, the review team identified many concerns in relation to Dr Watt's initial assessment of patients and the ongoing care provided, his clinical decision making including prescribing practice, and his communication with colleagues and with patients and their families. However, with reference to the definitions of harm that they were asked to consider, the review team concluded that the potential harm identified was low.
Examples of potential low harm:

- Prescription of numerous medications and/or frequent and rapid escalation of the dosage of medications without adequate advice being provided to the patient about potential side effects and monitoring for these (**in all cases**).
- A lack of coordinated multidisciplinary care (**RCPXXXX**, **RCPXXXX**).
- A failure to effectively advocate for the patient when the results of important investigations were not promptly available (**RCPXXXX**).
- Potential misdiagnosis of epilepsy and resulting unnecessary prescription of anti-seizure medication (**RCPXXXX**). The patient was documented to have experienced side effects from one

drug and was described by his family as experiencing multiple side effects over time and becoming increasingly withdrawn and worried about seizures after the diagnosis.

- Failure to adequately monitor the impact of medications with potentially harmful side effects (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**).
- Failure to explore potential alternative causes for the patient's symptoms which, if confirmed, may have altered the treatment provided (**RCPXXXX**).
- A lack of signposting to services which could provide support to the patient and their family and enable advanced care planning (**RCPXXXX**, **RCPXXXX**, **RCPXXXX**, **RCPXXXX**).

5 References

1 National Mortality Case Record Review Programme. https://www.rcp.ac.uk/resources/national-mortality-case-record-review-nmcrr-programme-resources/ [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 Michael 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 the Regulation and Quality Improvement Authority (RQIA) to 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.

A third phase (Phase 3) involves a review of the clinical records of two further groups of deceased patients. In each case the patient's family has approached RQIA to confirm that they wish to proceed with an expert review of their relative's clinical records. The review of the records of the first group of 18 patients under this phase (Phase 3 Group 1) was commissioned in July 2024 and took place in early 2025.

In July 2024, The Department of Health asked any further families of deceased patients of Dr Watt who wish to explore involvement with the review to contact RQIA by no later than 31 December 2024. These terms of reference relate to the final group of 8 patients (Phase 3 Group 2) whose families confirmed within that period that they wished to proceed with the review of their deceased family member's clinical records.

The RCP and the Association of British Neurologists agreed 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 care is in line with national good practice and guidelines, and/or what would be considered by the view of a body of clinical professionals in a similar situation.

Stage 1 (to be completed prior to Stage 2)

The RCP will provide an independent and expert review of the records eight 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

Whilst 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 that 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 and 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 the 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 signpost the RQIA to refer to a medical examiner or coroner to reconsider the case.

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 (London) and the Regulation and Quality Improvement Authority on 25 September 2025.

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.