The Regulation and Quality Improvement Authority

press release

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RQIA Publishes the Report of the Expert Review of Records of Deceased Patients (Neurology)

Today, RQIA has published the Report of the expert review of the clinical records of 44 deceased patients who had been under the care of Dr Michael Watt, a former Belfast Health and Social Care Trust Consultant Neurologist.

At the direction of the Department of Health, RQIA engaged the Royal College of Physicians (RCP) to undertake this expert review of the deceased patient records.

The review found that there were significant failures in the care and treatment of patients. The Expert Panel highlighted concerns over clinical decision-making, diagnostic approach, communications with other clinicians, and poor communication with patients and with families. The Expert Panel also reported that they were deeply saddened by the accounts provided by families.

Announcing the publication of the Report of the Expert Panel, RQIA's Chair, Christine Collins said:

> **"I commend the courage and openness of all those families who came forward to engage in this Review. Family accounts starkly illustrate how failings by an individual practitioner, and by the system, led to deep human impacts and resulting harm, both to the deceased patients and to their bereaved families."**
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> **"While this process has been difficult and may not have produced the outcome sought by some families, RQIA sincerely thanks every family for their patience, their personal commitment and the invaluable contribution they have made on behalf of their loved ones.**
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> **As Northern Ireland's independent regulator for health and social care, the Authority is committed to using its role and powers to ensure that the recommendations within this report are implemented "**

RQIA's Chief Executive, Briege Donaghy, said:

> **"Our staff, have been deeply moved through our involvement with the bereaved families. We are determined that the actions we take, driven by the findings from this Review, will improve clinical practice, the safety of services and the experience of patients and of families."**

The Report of the Expert Review of the Records of Deceased Patients (Neurology) is available on RQIA's website.

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Notes to Editors:

The RQIA was established by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is an independent health and social care regulatory body, whose primary duties are to keep the Department informed about the quality and availability of health and social care services, ensure regulatory compliance, and encourage improvement in the quality of services.

Under commission from the RQIA, in August 2020 the Royal College of Physicians (RCP) established Expert Panel to review the records of 45 deceased patients who at some point in their lives had been under the care of the physician referred to as Dr Y. The panel also considered family concerns where these were provided.

The review team comprised three specialist reviewers, all experienced neurologists of good standing, as well as the medical director and immediate past medical director of RCP invited reviews. The review manager was an experienced lay reviewer.

The Expert Panel produced two reports which examined the records of two groups of deceased patients. The "Cohort 1 Report" included 29 patients whose families had contacted RQIA with concerns about the care and treatment of their relative. The "Cohort 2 Report" focuses on 16 patients who had been included in the Belfast Trust's Cohort 1 neurology recall, who unfortunately died before attending or completing their reassessment. The expert panel excluded one patient from this group as there was no evidence in their records that they had ever been under Dr Watt's care, thus bringing the total number of cases reviewed to 44.

The key findings from this Review include:

- There was a lack of empathy and often a failure to consider patients' needs holistically.
- There were concern over the assessment and initial management of patients; aspects of clinical decision-making; diagnostic approach; prescribing; the communications and engagement with other clinicians; and interactions with patients.
- The review team identified concerns or omissions and their potential to lead to harm in almost half of the cases examined, including that some of the treatments prescribed were unnecessary and invasive.
- In several instances, the review team believed patients had been denied holistic, supportive care that may have made their condition, and ultimately end of life care, easier to manage.
- In almost half the cases reviewed the team did not consider the diagnosis to have been secure.

- While in most cases, the review team did not identify any concerns with the recorded cause of death, they stated that in several instances the review of death certification, or referral to a medical examiner or coroner, was recommended.
- The review team concluded that more than half of cases were graded “poor care” or “very poor care” in terms of initial management of the patient, and that clinical decision making was “poor” or “very poor”.
- They found that more than half of cases reviewed there was “poor care” or “very poor care” in terms of communication with colleagues, and that there was little evidence that multidisciplinary team input into complex cases was sought.

Throughout Phase 2 of this review, a personalised programme of family engagement was undertaken by a dedicated Family Liaison Team established by RQIA. Team members included RQIA’s Clinical Lead; a highly experienced external clinical advisor; a clinical psychologist; and the project lead with assistance from a family liaison support officer. This team engaged directly with those families who wished to describe their experiences of the care provided to their loved one, which was fully considered by expert review team.

The Review’s Ethical Advisory Group developed an ethical framework, and RQIA also developed an Involvement Framework, to help guide this family engagement work in a sensitive and professional manner, taking account of individual family preferences, and ensuing families were kept updated on the review’s progress. Where required, access was also provided to independent counselling services.