Written Ministerial Statement

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Department of Health

RQIA NEUROLOGY DECEASED PATIENTS REVIEW (DPR)

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Mr Butler (The Minister of Health): I wish to inform Members of the publication of the Regulation and Quality Improvement Authority's (RQIA) 'Final Report on the Expert Review of Records of Deceased Patients (Neurology)' and the completion of the Neurology Deceased Patients Review (DPR).

The publication of this report marks the conclusion of a significant programme of work commissioned following the recall of patients of former consultant neurologist Michael Watt.

First and foremost, I wish to acknowledge the families who have participated in this process. I recognise the profound loss they have experienced and the determination they have shown in seeking answers on behalf of their loved ones. I would like to offer my sincere apology for the distress caused to patients and families affected by these matters. I also wish to express my gratitude for their cooperation, patience and continued engagement throughout the review process.

On 2 May 2018, the Department announced the recall of patients of former consultant neurologist Michael Watt and directed the RQIA to commission an Expert Review of the clinical records of patients who had died in the ten years prior to the recall.

Phase Two of the Deceased Patients Review commenced in April 2021, when RQIA commissioned the Royal College of Physicians (RCP) to establish an independent Expert Panel to review the records of deceased patients. The Panel reviewed the clinical records of 44 deceased patients and, where available, considered testimony provided by families. The overarching Phase Two reports were published by RQIA in November 2022 and are available on the RQIA website at https://www.rqia.org.uk/reviews/deceased-patients-review/

In July 2024, the Department outlined arrangements for a further phase of review work. Following engagement with affected families, RQIA commissioned a Phase Three review consisting of two groups of cases. The review was completed in May 2026 and examined a further 25 patient records, comprising 18 cases in Group 1 and seven cases in Group 2.

The report published today represents the completion of RQIA's work reviewing deceased patient records linked to Michael Watt.

The findings set out within the report are deeply concerning. Consistent with findings from Phase Two of the review, significant failings in patient care and treatment were identified. The report highlights concerns regarding clinical decision-making, diagnostic approaches, communications with other healthcare professionals, and engagement and communication with patients and their families.

The review concludes that, in many cases, the quality of care assessed fell below the professional standards that patients and families were entitled to expect. It further reinforces earlier findings relating to isolated clinical practice, insufficient challenge and inadequate multidisciplinary oversight. The consistency of findings across both Phase Two and Phase Three demonstrates the importance of ensuring that lessons continue to be learned and embedded across our Health and Social Care system.

The report also recognises the courage and persistence of the families who sought answers on behalf of their loved ones. By sharing their experiences, they have helped to improve understanding of the impact that poor care can have on patients and families and have made an important contribution to patient safety improvement.

Yesterday, I had the honour of addressing family members present at the RQIA hosted event for families involved in the Deceased Patient Review. The event provided an opportunity to acknowledge the impact on families, recognise their contribution to the review process, present the findings of the report and reflect on the enduring legacy of this work.

As the review programme concludes, the Department and RQIA will consider the lessons arising from this work and how these can continue to inform improvement across the Health and Social Care system.

I would like once again to thank all those families who participated in this review. Their determination to seek answers on behalf of their loved ones has made an important contribution to strengthening patient safety and improving services for future generations.