1 Monday, 30 September 2024
2 **(09.59 am)**
3 **LADY JUSTICE THIRLWALL:** Good morning, Mr De La Poer.
4 I understand we have got Sir Robert Francis this
5 morning?
6 **MR DE LA POER:** My Lady, yes please.
7 **LADY JUSTICE THIRLWALL:** Sir Robert, would you come to the
8 witness box to be sworn, please.
9 **SIR ROBERT FRANCIS (sworn)**
10 **Questioned by MR DE LA POER**
11 **LADY JUSTICE THIRLWALL:** Please sit down.
12 **A.** Thank you.
13 **MR DE LA POER:** Sir Robert, please could you state your full
14 name?
15 **A.** Robert Anthony Francis.
16 **Q.** Sir Robert, we are going to begin my questioning of you
17 by introducing you and everybody will know that you have
18 had a long and distinguished career and your CV is set
19 out in appendix 3 of your report.
20 What we are going to cover now in the next couple of
21 minutes is just a selection of that.
22 Is it right that you were called to the Bar in 1973?
23 **A.** I'm afraid so.
24 **Q.** Appointed Queen's Counsel in 1992?
25 **A.** Yes.

1 **Q.** A Recorder of the Crown Court in 2000?
2 **A.** Yes.
3 **Q.** You were authorised to sit as a Deputy High Court Judge
4 in 2009?
5 **A.** Yes.
6 **Q.** You retired from those judicial roles in 2020?
7 **A.** I did.
8 **Q.** As a practitioner, did you specialise in clinical
9 negligence healthcare, professional discipline and
10 medical decision-making?
11 **A.** Yes, I did.
12 **Q.** And as a practitioner, did you appear for interested
13 parties in, among others, the Bristol Royal Infirmary
14 Inquiry and the Royal Liverpool Children's Hospital
15 Inquiry?
16 **A.** Yes, I did.
17 **Q.** In terms of chairing Inquiries, were you the Chair of
18 both the Non-Statutory and Statutory Public Inquiries
19 into Mid Staffordshire NHS Foundation Trust?
20 **A.** Yes, I was.
21 **Q.** You reported in 2010 and 2015 respectively in relation
22 to those two inquiries?
23 **A.** 2013, I think.
24 **Q.** Forgive me, 2013.
25 Did you also conduct a review in 2015 entitled "The

1 Freedom to Speak Up Review"?
2 **A.** Yes, I did.
3 **Q.** Have you given evidence as an expert on leadership and
4 culture to the Independent Inquiry into Child Sexual
5 Abuse in 2020?
6 **A.** Yes.
7 **Q.** As well as giving evidence to Parliamentary Select
8 Committees on a number of occasions?
9 **A.** Yes.
10 **Q.** More recently, were you commissioned by the Cabinet
11 Office to propose a framework for compensation for those
12 affected by the Infected Blood scandal?
13 **A.** Yes.
14 **Q.** And are you currently the Interim Chair of the
15 Compensation Committee?
16 **A.** Yes, I am.
17 **Q.** Finally, do you hold honorary fellowships from a number
18 of Royal Colleges and an Honorary Doctorate of Medicine?
19 **A.** Yes, with some embarrassment.
20 **Q.** You were of course knighted for services to healthcare
21 and patients in 2014?
22 **A.** Yes.
23 **Q.** So having provided that brief introduction, I am going
24 to turn now to your reports.
25 You have provided a report which comprised three

1 elements, Part 1, Part 2 and the appendices; is that
2 correct?
3 **A.** Yes.
4 **Q.** And they were all dated 30 May 2024?
5 **A.** Yes.
6 **Q.** And is the contents of those reports true to the best of
7 your knowledge and belief?
8 **A.** Yes, whether they are now entirely up to date I don't
9 know, because some things move very quickly in this
10 field.
11 **Q.** And so that everybody understands, those reports, if
12 they have not already, will be published on the Inquiry
13 website in their entirety which will mean that you and
14 I will not need to go to every single paragraph of them.
15 So the first substantive topic that we are going to
16 consider together is NHS structures.
17 **A.** Yes.
18 **Q.** That is in section 1 of your Part 2 Report.
19 **A.** Yes.
20 **Q.** I am just going to begin with some of your preliminary
21 observations about NHS structures and then just
22 a whistlestop tour of the reforms.
23 So starting with your preliminary observations, how
24 would you suggest a person should think about the NHS in
25 terms of how it is structured?

1 **A.** Well, people tend to think of the NHS, if they don't --
2 haven't looked at an organisation diagram as though it
3 was one single entity called the National Health
4 Service, which of course its object is to provide care
5 to all free at the point of delivery insofar as they
6 need that care.
7 In fact, it is a -- and I have described this as
8 a series of planets, really, a whole series of
9 organisations which together provide a service and I use
10 the word "together" somewhat loosely.
11 The funding obviously comes from the Government,
12 from the taxpayer and is filtered down through the
13 Department of Health to a number of different entities.
14 But you know if one starts with a point of the patient
15 coming to a general practitioner or a hospital, each
16 place, each organisation, that the doctor works in will
17 be different.
18 So there is a different organisation running the
19 hospital, different organisation running the general
20 practice surgery, and obviously a different person
21 running the chemist shop.
22 So there are a whole load of different entities that
23 actually are called "service providers" who actually
24 provide the service to patients.
25 **Q.** So those service providers are, would it be correct to

1 observe, what people commonly refer to as "the front
2 line"?
3 **A.** Yes.
4 **Q.** Surrounding that front line, you mention in your report
5 that there are a large number of regulatory and
6 oversight bodies?
7 **A.** Yes.
8 **Q.** And you make an observation, and I would just like for
9 you to repeat here about how many of such bodies there
10 are.
11 **A.** Well, the truth is that I don't know and I am not sure
12 anyone does. I notice Professor Dixon-Woods actually
13 put a number to it last week and said there were I think
14 106 bodies and there were a few more all having some
15 form of regulatory influence, as she put it, on the
16 provision of services.
17 I thought when I did the Mid Staffordshire report
18 from memory that there were some 60 bodies that had
19 direct regulatory power. An example would be the
20 General Medical Council who regulate doctors, the
21 Nursing and Midwifery Council who regulate nurses and in
22 those days the Healthcare Commission, now the Care
23 Quality Commission that actually inspects premises and
24 providers of healthcare services and regulates them.
25 There are different regulators that look at the finances

1 of NHS Foundation Trusts and I could go on. But there
2 are a very large number of regulators, and some argue
3 too many.
4 **Q.** Returning to the front line and your experience of
5 hearing from front line workers, what is the effect or
6 your impression of the effect of that vast amount of
7 regulation on those who are delivering care?
8 **A.** I think many front line workers, principally I would say
9 doctors and the nurses, if I could simplify it a little,
10 find that puzzling and intimidating and leaves them
11 sometimes uncertain as to where they should go if they
12 have concerns to raise.
13 They also have conflicting obligations, not in the
14 sense that their employer wants to go against what the
15 General Medical Council would require of a doctor,
16 simply the Codes of Practice or conduct that an employer
17 might have, will incorporate what the
18 General Medical Council expects but will also have other
19 things in it as well.
20 So it is a very complicated picture for a busy
21 professional to get their head round if a crisis
22 develops.
23 **Q.** You have mentioned doctors and nurses. Is any challenge
24 presented by this overarching regulatory regime to those
25 who are managing hospitals?

1 **A.** Definitely. For a number of reasons.
2 A common complaint as long I have been interested in
3 this field amongst the -- those who manage and lead the
4 healthcare providers is the burden placed on them of
5 having to provide information to regulators. Often the
6 same piece of information is required in a number of
7 different places but at different times and in different
8 forms. So the bureaucratic burden of collecting data
9 and passing it on is immense.
10 There is also an issue around, if I can put it
11 broadly, of discipline and of control of that nature of
12 staff because each professional member of staff
13 depending on their profession will have a different
14 professional regulator with whom the employer has to
15 interact in relation to the behaviour of their staff and
16 that in itself can cause hesitation, I think,
17 uncertainty whether a matter should be dealt with
18 internally or externally.
19 **Q.** Staying on the subject of senior managers and speaking
20 in general terms, what has been your observation about
21 the effect of turnover in terms of those senior managers
22 operating within that structure?
23 **A.** Well, I was going to say start by saying, I will say it,
24 that the one group of people who don't appear to be
25 subject to regulations at all are the senior managers

1 and that has a number of consequences. One is that
2 there is no common standard for or qualification
3 required to be for instance the Chief Executive of
4 a large Hospital Trust, multi-million -- billion pound
5 operation and there is no qualification for doing that.
6 Secondly, it means that they, of all people sitting
7 round a board table, are the -- are not subject to
8 a regulator as such. But they are subject to orders
9 from on high, if you like, orders from the centre,
10 mandates, directions which come down in huge volumes and
11 expectations and their job is to fulfil those
12 expectations, most which of course are extremely well
13 intentioned.
14 But the pressure on them particularly today in
15 relation to delivering a health service with constrained
16 funds, increasing demand, often the shortage of staff is
17 immense and the stress of that is also immense and
18 therefore these aren't the most popular jobs on the
19 planet, putting it frankly, and the skills required are
20 the same, if not greater, than those perhaps required of
21 the chief executive of a FTSE 100 company.
22 And the consequences of getting it wrong or failing
23 to getting it right -- they are not necessarily the same
24 thing -- can be being sacked, being asked to move on,
25 asked to resign and for many people that's difficult.

1 So you do have a big turnover and when I wrote this
2 report and when I was doing the Mid Staffordshire
3 report, the length of tenure of a director, an Executive
4 Director of the NHS, was remarkably short, I think at
5 one point it was under two years for a Chief Executive.
6 It is now better than that but not much. When you
7 consider that there are some successful Chief Executives
8 who have been in place for 10 or even 15 years a lot
9 have not stayed very long.
10 The difficulty about that is of course you lack
11 continuity. It takes anyone leading a complex
12 organisation time to get the measure of the job and the
13 authority to do it and if it is known they are not going
14 to be there very long then perhaps they don't get
15 listened to very carefully.
16 So it has a sort of self-perpetuating effect the
17 more difficult the job gets, and that's true of course
18 of failing organisations: the more difficult it is to
19 find good people to come and take over those roles.
20 **Q.** We will return to the topic of accountability of senior
21 managers as its own discrete area but just before we
22 look at the history of the NHS, you cite in your report
23 at 1.5 from the Messenger Leadership Review and before
24 I just invite you to speak to that, can you just give us
25 a thumbnail sketch of what the Messenger Review was for

1 those that perhaps don't have that information at their
2 fingertips?
3 **A.** Yes. Well, General Sir Gordon Messenger was asked to do
4 a review of how -- of leadership and culture of
5 leadership in the NHS from, as it were, an external
6 point of view and he basically found I think the sort of
7 things I have been describing: a difficulty in
8 recruitment, lack of support by way of training, and
9 perhaps a lack of understanding of the type of culture
10 required to run a healthcare organisation.
11 This particular passage though was about something
12 I have mentioned which is the constant demand to produce
13 statistics and measurements, whether they be financial,
14 or of outcomes, all of which I should hasten to add are
15 well intended because clearly the centre needs to know
16 what's happening at the front line, but I think what he
17 was getting at was the lack of co-ordination of some of
18 these demands with different organisations, such as the
19 Care Quality Commission on the one hand, NHS England on
20 the other, sometimes the Department of Health directly
21 of continually asking for streams of information, some
22 of which is automated now so it's easier for it to be
23 done but all in different formats and often about the
24 same subject and so they spent a lot of their time
25 delivering on feeding the machine, as it were, with

1 information.
2 **Q.** One of the recommendations of the Messenger Review as
3 you record below the quotation is a change from
4 a punitive model to a remedial one?
5 **A.** Yes.
6 **Q.** In summary, what do you understand that to mean and do
7 you think that that is a step in the retrospective
8 direction?
9 **A.** I do. What I think is meant by this is that despite
10 a number of attempts to give the front line
11 organisations more independence of judgement and of
12 action, the reality is that the centre by which in this
13 case is represented really by NHS England who are the
14 commissioning body for the entirety of the NHS because
15 they hold the purse strings seek to control what is or
16 try to control what is happening further down the
17 financial food chain and therefore, understandably
18 perhaps, there are constant conversations and pressures
19 about how NHS Trusts and providers spend the money. And
20 there is a constant conversation going on with the
21 provider saying: I need more money to provide a safe
22 service and the centre saying: some people are doing it
23 on what you are getting, why can't you do it?
24 Then what happens is that if the service is not
25 provided in the way that is expected, the

1 Chief Executive is expected to take responsibility and
2 that's one of the obvious reasons why the Chief
3 Executive then departs, either because they are
4 dismissed, more usually you will see an announcement
5 that they have decided either to spend more time with
6 their family or even more often, actually, they have
7 gone to a different job elsewhere in the health service.
8 Another way in which is punitive is and I used to
9 sit on the board of the Care Quality Commission and
10 therefore often used to see their inspection reports
11 before they were published, but I didn't have to because
12 quite often before the report would be published, the
13 Chief Executive of the Trust would depart,
14 coincidentally of course from his role or her role, and
15 that was because that responsibility of downgrading of
16 the rating of the Trust would be taken by the
17 Chief Executive.
18 I always thought that was often wrong, sometimes of
19 course Chief Executives are not up to the job but more
20 often they haven't been given the tools to do the job
21 properly but then they are asked it bear the personal
22 consequences of that rather than anyone trying to sort
23 the system out.
24 So I think what Sir Gordon was saying, and what
25 I would agree with, is that in terms of a remedial

1 system you need something that supports Chief
2 Executives, their boards, to do their job well rather
3 than continually holding a stick over their head and
4 implying that if you don't do this, then you won't have
5 a job.
6 **Q.** So having given us what some may feel is a slightly
7 bleak summary of where things are --
8 **A.** I should say the positive -- we do always of course talk
9 about the negative. There are many good Chief
10 Executives and leaders who cope with these pressures and
11 actually do manage to deliver what they are expected to
12 deliver. But some might argue that many do that despite
13 the system rather than because of it.
14 **Q.** It was to a positive that you identify that I was just
15 leading up to. You have obviously had the opportunity
16 to meet very many front line healthcare providers and
17 their managers and to hear from them firsthand. What
18 you say near the start of your report is that there is
19 a constant culture of very dedicated people who work in
20 it and lead in it who often agree on values, the outline
21 of strategic thinking and actions required to bring
22 about improvement, but find it impossible within their
23 own area to integrate and develop these in their own
24 contexts.
25 So perhaps the other side of the coin that we are

1 talking about is that at a human level your experience
2 is extremely positive?
3 **A.** Yes, I think that's right. I mean, it is an essential
4 to be a leader in these complicated organisations to
5 develop the competencies to do it, to have had
6 appropriate training but perhaps more important low
7 experience that leads you to the job.
8 The problem sometimes, and this was the case at Mid
9 Staffordshire, was that there were not many applicants
10 for the job and a choice had to be made between two
11 candidates that, frankly, the evidence showed no one was
12 hugely enthusiastic about and that's terribly unfair on
13 the person who then gets the job in those circumstances
14 whereas -- and I am not going to name them -- I could
15 name some Chief Executives currently in post in this
16 country who have a marked record of success and we might
17 come to it, there are certain things about the way they
18 go about their business which makes it more likely that
19 they will succeed than perhaps others.
20 **Q.** Well, we will certainly come to that. Can I take you
21 please to paragraph 1.9 of your report, which is on
22 page 3. We are not going to speak to all the detail
23 here but just work through the evolution of where we
24 were to where we have got to --
25 **A.** Yes.

1 **Q.** -- just as part of this scene-setting and then we will
2 move on to a number of topics which directly engage the
3 facts surrounding the Countess of Chester.
4 So the first date you go to, 1973, we see the
5 introduction of Regional Health Authorities and Area
6 Health Authorities, we don't need to go to the precise
7 statutory mechanism by which that came about.
8 But seven years later the Area Health Authorities
9 were disbanded and became District Health Authorities;
10 is that correct?
11 **A.** Yes.
12 **Q.** In 1984, a significant moment in the evolution of the
13 NHS, the Griffiths report, which recommended effectively
14 an increase in the number of managers so as to support
15 the doctors and nurses who were providing the care?
16 **A.** Yes, the position before that, I think was -- obviously
17 I am testing my memory a little -- that there was
18 a slightly amateur nature in terms of the management of
19 hospitals in particular, the great and good of the
20 district would be on a board, the place would be largely
21 run by the Medical Director and/or the Matron together
22 and it would be that sort of atmosphere and of course
23 what Griffiths correctly identified was that management
24 administration and leadership are skills which aren't
25 necessarily bred into anyone who is a doctor or a nurse.

1 This is a separate professional skill.
2 So he wanted that to be brought in but he also
3 emphasised that clinicians are a very important part of
4 the structure should remain so. It's often been
5 interpreted that his recommendations were there should
6 be this sort of entirely new management class separate
7 and above the professionals and that I don't think was
8 his intention.
9 **Q.** So that recommendation in 1984, we move forward to 1990,
10 where the NHS Management Board becomes the NHS
11 Executive?
12 **A.** Yes.
13 **Q.** And at this moment in time the idea of an internal
14 market was imposed on the NHS where there would be
15 purchases of healthcare and providers designed to make
16 the State an enabler, you say, of health services rather
17 than the supplier?
18 **A.** The idea behind this, as I would understand it, was to
19 bring an element of competition into the service so that
20 with the premise being that competition between
21 different units of health care provision would improve
22 meaning they would all be incentivised to improve their
23 standards.
24 The slight difficulty about that was that of course
25 in order for there to be competition you actually had to

1 provide choice, real choice to patients as to where they
2 would go for their medical care and of course for many
3 of us, particularly in more rural parts of the country,
4 you have no choice where you go for your medical care on
5 the NHS; the local hospital is the local hospital.
6 But it led to the development of a very
7 complicated -- necessarily complicated -- commissioning
8 system of purchasers and providers.
9 **Q.** We then see at 1.9.6 the first of three waves of NHS
10 Trusts?
11 **A.** Yes.
12 **Q.** Obviously a legal identity for the particular healthcare
13 provider?
14 **A.** Yes, and part of that was to introduce the concept of
15 a Board of Directors so to make the NHS a bit more
16 comparable with an outside company in terms of how --
17 what its management and governance structure would be.
18 **Q.** We then see another change in the overarching structure
19 where Regional Health Authorities and District Health
20 Authorities become Health Authorities?
21 **A.** Yes.
22 **Q.** 1997, the newly elected Labour Government wishes to
23 maintain the purchase of provider split but abolish the
24 internal market. Just very briefly, in practical terms
25 what did that mean?

1 **A.** I am not entirely, entirely sure. I think the position
2 was that commissioning remained and so basically, as is
3 I think the case today, providers have to set out their
4 business case for what it is they want to do. The
5 centre can decide -- and it now does it in a different
6 way -- what needs to be commissioned to reflect the
7 needs of the local or the national community and so
8 there is this -- there is a commission of customer
9 service provider relationship.
10 So in theory the Commissioner will set out the terms
11 of service to be -- and standards of service to be
12 provided by the provider and one of the challenges
13 I found when I looked at this in the Stafford Inquiry
14 was that there was an understandable emphasis on how
15 much things cost. There were provisions about the
16 quality of what was to be provided but those were not
17 monitored in a way that the financial performance was.
18 So there was always a priority of examining the finance
19 over monitoring how well the service was -- what the
20 quality of service was like for the customer, the
21 patient.
22 **Q.** 1998, an organisation everyone will have heard of, NICE,
23 established to assess costs and benefits of intervention
24 and make recommendations?
25 **A.** Pausing there, it is only one sentence but I think it

1 would be fair to say in my view NICE has been one of the
2 successful reforms in that it provided a rational and
3 objective means of assessing the benefit of treatments
4 and providing guidance about standard ways of offering
5 treatment in a very challenging landscape, where there
6 would be competing demands for treatment, you know,
7 between people, cancer and heart patients for instance,
8 always new drugs always being brought in, was this
9 something the NHS should pay for and previously it was
10 very difficult for anyone to form an objective judgement
11 about these things.
12 NICE provides a means of working out whether it is
13 worth the taxpayer paying for a particular type of
14 treatment and also how that treatment ought to be
15 provided.
16 **Q.** Moving forward, we have Primary Care Groups in 1999,
17 although -- and the Commission for Health Improvement
18 which had the power to review governance in every NHS
19 organisation which you identify as the first time there
20 was independent regulation of clinical performance?
21 **A.** I think that's right, yes. The Commission for Health
22 Improvement then changed its names and there is
23 a confusion of successive bodies that occurred since
24 then but that I think was the start of that.
25 **Q.** In terms of 2000 we see The NHS Plan and payment by

1 results?
2 **A.** Yes.
3 **Q.** And two years later the introduction of Foundation
4 Trusts which is plainly of an important moment in time
5 given the Countess of Chester status?
6 **A.** Yes.
7 **Q.** We will come back to Foundation Trusts in due course.
8 We then see that succession that you have talked about
9 2002 also the Commission for Health Improvement merged
10 with the National Care Standards Commission to become
11 the Commission for Healthcare Audit and Inspection?
12 **A.** Yes.
13 **Q.** 2004 the formal introduction of the NHS Foundation Trust
14 and the establishment of Monitor as its regulator?
15 **A.** Yes, Monitor was set up to basically provide the
16 financial regulation of NHS Foundation Trusts and it
17 played an important role in assessing in advance whether
18 an NHS Trust was financially healthy enough to be given
19 the autonomy that a Foundation Trust was theoretically
20 going to have.
21 It was also meant to look a little at the safety and
22 quality but that was largely in the remit -- that part
23 was largely in the remit of the other regulator, the
24 Healthcare Commission.
25 **Q.** So moving forward in time an example of perhaps

1 something that comes and goes, World Class Commissioning
2 in 2008 introduces a concept but within two years, your
3 understanding is that it was abandoned?
4 **A.** Yes, commissioning wasn't abandoned but this particular
5 method, particularly its name I think in the end, was
6 perhaps thought to be slightly ambitious.
7 **Q.** We then see a combining of regulators to create the Care
8 Quality Commission in 2009?
9 **A.** Yes.
10 **Q.** And in 2012, referred to as the Lansley Reforms, where
11 the function for commissioning was given to what were
12 called Clinical Commissioning Groups, or CCGs?
13 **A.** Yes.
14 **Q.** You say here the system regulator was renamed "Monitor".
15 **A.** Yes, that can't be right because we -- no, I think I am
16 not sure about the date.
17 **Q.** Not sure about the date but at any event, Monitor --
18 **A.** I think the regulator was there. I think that was when
19 it became known as "Monitor".
20 **Q.** Yes. So we have got to a moment in time which is just
21 before the facts that this Inquiry is focusing upon and
22 in 2013, the Department of Health published a diagram
23 which sought to explain to members of the public, and
24 probably those who operated within the system, how
25 healthcare was provided by the National Health Service

1 and it is perhaps, you will agree, a not dissimilar
2 diagram to the visualisation you suggested of orbiting
3 planets?
4 **A.** Well, this diagram I took from the Department of
5 Health's website and it was its diagrammatic explanation
6 of the health service and what slightly amused me was
7 that all these bodies seem to go round in an orbit but
8 none of them seem to be connected with each other and
9 one can always criticise a diagram and make fun of it.
10 But it seeks clearly and correctly to make people, the
11 patients, the most important part and at the centre of
12 things. But it doesn't really reflect the relative
13 importance or in terms of the influence really of any of
14 the bodies that float around the outside.
15 But what it does do, I think, is give you an idea
16 the complexity in terms of the number of organisations
17 from the outside going inwards which have a role and
18 often a changing role in how they influence the delivery
19 of care to the people and the communities in the middle.
20 **Q.** Moving forward in time, we can take that down, thank you
21 very much. We had the NHS Five Year Forward View in
22 2014 which called for better integration of healthcare
23 services and the development of local plans?
24 **A.** Yes.
25 **Q.** And then, three years later the Next Steps on the

1 Five Year Forward View which put forward national
2 priorities for the next two years; is that correct?
3 **A.** Yes.
4 **Q.** In 2017 the establishment of the Health Service
5 Investigation Branch, HSIB, and what was the function of
6 that body?
7 **A.** Well, until then, there was only a limited resource
8 centrally for the investigation of things that would
9 go -- had gone wrong for -- in terms of adverse
10 incidents and the idea behind this branch was to bring
11 into the health service some of the techniques used for
12 instance in the aviation industry and in transport,
13 actually rail transport, for undertaking what I will
14 call no blame investigations; in other words to examine
15 in an objective and expert way why something had gone
16 wrong without attributing blame to anybody in
17 circumstances which were intended to encourage people to
18 be frank and open about things that had gone wrong.
19 So in the aviation industry, for instance, if
20 an accident happens with a plane, and the pilot survives
21 the pilot can explain what happened in an entirely
22 confidential way to the relevant authority, produce
23 a report having looked into the matter, to describe what
24 went wrong and what lessons there are to be learned for
25 it without any of that evidence capable of being used

1 to, as it were, punish the pilot if they made a mistake.
2 So it was -- the idea is to have an objective
3 investigation with a full and frank disclosure to the
4 investigators from everyone concerned. So that was the
5 idea and this was the first iteration -- not the last,
6 but the first iteration of that process.
7 Of course, being a central body, I should say
8 straight away, and given the large number of adverse
9 incidents there are, inevitably it could not deal with
10 them all and therefore it's had to be selective about
11 which incidents it would choose to investigate and it
12 usually done it on a thematic basis.
13 **Q.** Just a couple more dates. 2019 the creation of Primary
14 Care Networks.
15 **A.** Yes.
16 **Q.** You say there about 1,250 Primary Care Networks?
17 **A.** Yes.
18 **Q.** Now, staying with the subject of reforms 2022, you say
19 this gave:
20 "The Health and Care Act 2022 gave legal
21 confirmation to organisational changes that had
22 previously been occurring in 'shadow' form, following
23 the Long Term Plan, by the abolition of clinical
24 commissioning groups ..."
25 Those are the CCGs that we spoke about a moment ago ,

1 and the introduction of Integrated Care Boards and
2 Integrated Care Partnerships?
3 **A.** Yes. The idea behind this and this is now what -- what
4 we have, the idea of the Integrated Care Board is to
5 bring together the healthcare providers of a particular
6 defined geographical area together with the social care
7 providers to make jointly plans with their joint budgets
8 to how to provide both health and social care in an
9 integrated way to the people of the locality and in
10 a somewhat complicated structure inevitably that's their
11 responsibility.
12 So as you will see from the diagram at
13 paragraph 1.9.28, the money now filters down from the
14 taxpayer through the Integrated Care Board to the
15 healthcare providers and via a different route to social
16 care providers now this diagram has other faults but
17 what at least it does is it does -- if you follow the
18 arrows -- show you how the money goes from Parliament
19 through the Department of Health to the various bodies
20 and right at the bottom in the middle is the box to NHS
21 providers and in that box sit all the hospitals and
22 I think I am right in saying would be all -- primary
23 care, as we see, comes down to the left through
24 NHS England.
25 But there is now the beginnings of an attempt, and

1 it is only the beginnings, I think, for the social care
2 budget to be fed into the local authorities and thereby
3 into this integrated system, but it is a far from
4 perfect union at the moment.
5 **Q.** And the --
6 **A.** Could I just say one thing about this diagram. One
7 thing I think this does show diagrammatically a little
8 better is that if you are in the position of the leader
9 of an NHS Foundation Trust in that box at the bottom,
10 you have coming down on you, through -- although it is
11 through NHS England rather than particularly directly
12 the Department of Health, but as the money is being
13 funnelled down from NHS England through the Integrated
14 Care Board to the NHS provider, the control is still
15 there.
16 NHS England is still controlling the budget that
17 comes down to the NHS Trust and there is still -- there
18 should be a dotted line, there is still the regional
19 directors of NHS England will be having direct
20 communication all the time with the hospitals,
21 particularly the ones who are in financial trouble,
22 seeking to sort out their finances.
23 **Q.** The final date in what has been a whistlestop tour,
24 2023, the Health Services Safety Investigations Body was
25 established, taking over from its predecessor which had

1 one fewer S in the title?
2 **A.** Yes. Yes, and it is in effect the same body but it has
3 now has the statutory powers and the importance of that
4 is that there is now a statutory protection in relation
5 to information given to this body which can only be
6 disclosed, this is the evidence as such, it can only be
7 disclosed with the benefit of a court order, basically.
8 **Q.** You draw things together at your paragraph 1.10 and
9 speak about, as we have just seen for ourselves, the
10 "continuous systemic change for the last 20 years".
11 I think you have already said that the trend was to
12 distance healthcare service from Government whilst
13 maintaining control of the money?
14 **A.** Mmm.
15 **Q.** But in your final sentence you make an observation in
16 that paragraph about how that impacts -- how the
17 structure impacts upon the culture.
18 **A.** Yes, my experience -- and it comes from not only writing
19 reports but then trying to see what's happened about
20 them -- is that there is a culture and it persists at
21 the provider level of waiting to be told what to do by
22 the centre and that's partly due to the fact that, as
23 you can see, reorganisations happen frequently and with
24 the best of intentions and because of perceived
25 problems. But it tends to be that no sooner has

1 an effort been put into -- and it often is a big effort
2 administratively, to change from one bit of the system
3 to another that you wait to be told what to do, and
4 even -- I mean, if -- I take we will come to it I know,
5 but my Freedom to Speak Up Review, the principles
6 enunciated there could have been immediately instituted
7 by any organisation straight away. There was nothing to
8 stop a Chief Executive doing that. Quite a lot of them
9 waited until a direction came from the centre to do it.
10 They didn't have to do that but that's what happened and
11 that's one thing.
12 The other thing is that the constant reorganisation
13 means that there is often a lack of stability. People,
14 for instance, in a Clinical Commissioning Group, or
15 whatever its predecessor was, will be worried about what
16 their next job is going to be. There will be a lot of
17 focus on transferring of one place to another often with
18 the result that the same person is doing the same job
19 with a different label on the door, but getting there
20 is -- causes anxiety, preoccupation and frankly takes
21 people's eye off the ball.
22 So those are the risks that have to be taken into
23 account when directing a reorganisation and I am not
24 sure that those risks are always taken into account.
25 **Q.** Thank you very much, Sir Robert.

1 We are going to move on from the topic of NHS
2 structure and consider the issue of NHS culture which
3 you deal with at section 5 of your Part 2 Report which
4 starts on page 38.
5 **A.** Thank you.
6 **Q.** It may very well be that we can take this relatively
7 shortly. I know that you have taken the opportunity to
8 consider the evidence of Professor Dixon-Woods who
9 gave her perspective on NHS culture and the challenges
10 it faces. Broadly speaking, do you find yourself in
11 alignment with what Professor Dixon-Woods was saying or
12 was there any part of what she said that doesn't match
13 your experience?
14 **A.** Frankly I thought she gave a very impressive analysis of
15 the -- first of all, the culture is what the problems
16 with it are and what the problem -- what the culture
17 should look like. I mean, it is actually one of the
18 features of this that if one looks back over any number
19 of Inquiries or the literature, that everyone's -- and
20 frankly if you go to patient safety conferences, as I do
21 from time to time, everyone is saying the same thing,
22 often in different words but it amounts to the same
23 thing and what worries me and puzzles me to this day is
24 that when they leave those conferences and go back to
25 wherever they come from in those places where that's not

1 the culture, nothing much seems to happen to change it.
2 So it is -- the mystery I think that needs solving
3 is how you create and maintain the culture universally
4 in a universal health service that is what everyone
5 would regard as a healthy culture.
6 **Q.** If we consider this issue by what emanates from the
7 centre.
8 **A.** Yes.
9 **Q.** And here I am looking at your paragraph 5.3.5, page 41.
10 **A.** Yes.
11 **Q.** You draw attention to the NHS Constitution?
12 **A.** Yes.
13 **Q.** Firstly, is that a document that you think has value?
14 **A.** I think it could have value. It should have value
15 because it is the obvious place where the common values
16 and principles, cultural principles of the NHS should
17 reside, as a common reference point for everybody.
18 It is a document that has statutory force, it is
19 reviewed on a regular basis by the Department of Health
20 the Secretary of State and I believe it's a document of
21 considerable value.
22 But it's, you know, a piece of paper, which is what
23 it is, is not enough to ensure the values that it
24 espouses are sort of lived by at the shop floor.
25 It is I think the place where the common values and

1 description of the healthy culture, if I can use that
2 expression, should be. But what happens and I am not
3 saying it is necessarily wrong, these are taken by every
4 single organisation in the NHS which then produces its
5 own values and principles, often frankly using the same
6 words but using the same values but different words, and
7 I think you end up with a plethora of documents that
8 don't necessarily lead to clarity.
9 **Q.** Well, you give some examples of particular Trusts at
10 5.3.1?
11 **A.** Yes.
12 **Q.** There is no need to go to the detail of them, but is
13 that something that you see commonly across the NHS?
14 **A.** Yes, if you look at any NHS Trust, Foundation Trust
15 website they will all have their values blazened in
16 a banner across the top and I absolutely understand that
17 if you are at the University College London or Morecambe
18 Bay or Birmingham Hospital you want to create your own
19 identity, your own corporate loyalty, we all know that
20 teams work better because they -- if they have that
21 sense of shared identity. And it's easier to feel that
22 loyalty to the place you work in rather than this
23 somewhat ephemeral concept of the NHS.
24 I am not saying they shouldn't do this but all I am
25 saying is that it does -- one of the risks of this is it

1 leads to a bit more confusion and lack of clarity about
2 where it is that someone should refer to when the chips
3 are down, where is the place I can go to to say this
4 value means what I must do is X?
5 **Q.** Now, when speaking about culture, you talk about safety
6 culture?
7 **A.** Yes.
8 **Q.** Can you just tell us what you mean by that and how
9 that -- I am here looking at 5.3.9, page 42?
10 **A.** Yes, well clearly a healthy culture involves more
11 than -- safety I think is one part of the culture but it
12 is a very important, if not the, in my view, important
13 part, which is that healthcare is by definition a risky
14 business and it requires people to understand and weigh
15 risks.
16 But, at the same time, safety as in terms of
17 avoiding harm to patients should be really the priority
18 because we all go to medical treatment hoping to be made
19 better, but at least not made worse by it and at least
20 in this we are told you have a hope of being made better
21 but there is a risk of you being made worse.
22 So you -- it is up to the patient to decide what
23 risk to take.
24 But most risks we are talking about are the
25 avoidable risks and so the health, a safety culture

1 requires people to be thinking all the time about safety
2 and the challenge in a busy place, like an Accident and
3 Emergency ward always is, is getting that notion across
4 and of course sometimes risks have to be taken because
5 there is no choice but there needs to be something
6 conscious about that and all the time when things for
7 instance go wrong, there needs to be this persistent
8 curiosity about why they went wrong, what the answer to
9 it is, and how we can avoid doing it in future and
10 that's not just a job you can give to the safety officer
11 to deal with. It has to be cultural because it's got to
12 be everyone's business.
13 These are easy things to say, they are rather more
14 difficult to put in practice, but if you don't start
15 with this insistence that we are going to run things
16 safely as best we can, in demanding circumstances, and
17 when things go wrong let's be honest about it, let's see
18 what we can do to put them right, then things will
19 inevitably get unsafe.
20 **Q.** In terms of the second part of what you said, so the
21 scenario in which things have gone wrong, you talk about
22 a "just culture"?
23 **A.** Yes.
24 **Q.** Again just summarise for us in terms of concept how that
25 interacts with a healthy culture?

1 **A.** Well, one of the features of the healthy culture, the
2 safety culture, the just culture, is the need for
3 absolute honesty and openness, we will come to some
4 aspects of this I am sure later, about what everyone has
5 done and why it happened. If you don't have that, then
6 you will develop unnecessary dangers in what you do.
7 So in order to do that, you have to relieve people
8 of the fear that if they raise a concern or they are
9 honest about a mistake they have made, that they will be
10 punished for it.
11 Now, no one I think suggests that punishment is not
12 appropriate or sanction is not appropriate where people
13 have been reckless or irresponsible or committed
14 a crime. No one is saying that. But generally
15 speaking, most dangerous activities in the NHS are
16 unintentional and there are reasons why they have
17 happened, but in order to learn about those and deal
18 with the idiosyncrasies of human behaviour which are
19 often behind this, there needs to be openness and
20 honesty and that's often immediately: I have just made
21 a mistake by putting a needle in someone in the wrong
22 way, please could you help me put it right?
23 If you are afraid that by putting the needle in the
24 wrong place you might end up being disciplined or maybe
25 even sacked or reported to your regulator, you will hide

1 what you have done, do your best to sort it out and get
2 on with the next case and hope no one notices.
3 But the more that happens, the more dangerous your
4 own practice will become but also the unit you work in
5 will become more dangerous, so that's what I mean by
6 just culture, it is a culture where people are not
7 afraid to admit they have done something that in
8 retrospect they shouldn't have done or they are not
9 certain that's the case and there is a free discussion.
10 Another part of it is that you are that afraid to
11 suggest that someone else could have done something
12 better without the fear of thinking that you will suffer
13 adverse or consequences for doing that.
14 **Q.** So focusing upon neonatal units which you do at 5.4,
15 page 47, in the middle of that paragraph, you make
16 an observation about the nature of such units and
17 I wonder if you could just speak to that, please, in
18 terms of why you single out that particular part of
19 a hospital in this context?
20 **A.** Well, in one sense all of us if we go for medical
21 treatment are vulnerable people because we are reliant
22 almost entirely on the professionalism of those we
23 approach for help to get things right.
24 I appreciate we can probably go and Google things
25 more than we used to and become quasi experts of our own

1 but that's usually ill-advised. Babies can't do that.
2 They can't -- they don't speak for themselves, they are
3 desperately ill, they are -- the difference between life
4 and death in a neonatal Intensive Care Unit can be
5 a matter of a tiny measurement on a machine.
6 Their parents speak up for them potentially if you
7 ask them and you allow them to but they have no advocate
8 for most of the time and so they are probably the most
9 vulnerable people in our society and therefore it would
10 seem to me and this is -- I have to say straight away
11 I have not had an inquiry that has dealt specifically
12 with neonatal care but my medical practice -- sorry,
13 professional practice as a barrister I spent a lot of
14 time dealing with accidents at birth or soon after
15 birth, so I am familiar with the issues that doctors and
16 nurses face and these are -- I maintain from that that
17 they are the most vulnerable people and therefore the
18 most exquisite care needs to be taken of their safety.
19 One would hope that that happens and would be
20 a given but unfortunately my experience is that things
21 are often assumed and therefore you do need systems that
22 make sure this is constantly in people's minds, that
23 they are vulnerable people who need the safest possible
24 care.
25 **Q.** Now we are likely to hear in the course of the inquiry

1 about the British Association of Perinatal Medicine?
2 **A.** Yes.
3 **Q.** And in particular about staffing guidelines that they
4 issued. Just looking at the global picture, you draw
5 attention to a 2015 report in terms of the national
6 level of compliance with the BAPM requirements or rather
7 guidelines, that's at your paragraph 5.4.3?
8 **A.** Yes.
9 **Q.** Can you just help us with what the position was?
10 **A.** Well, the position seemed to be if that report that
11 there was a shortage in relation to the minimum staffing
12 the experts considered was necessary to provide safe
13 care.
14 It is fair to say that this is not the only area in
15 which the issue of safe staffing has arisen and indeed
16 there has been for years now a general debate about how,
17 firstly how you should assess what is safe or unsafe in
18 any particular area but secondly, what the consequences
19 of not having a safe level of staff might be.
20 One of the dilemmas obviously is that if you have
21 sick babies in particular perhaps, closing down a unit
22 because it hasn't got a safe number of staff may not be
23 an option because these poor babies have to go
24 somewhere. But the consequence of not having the staff
25 that the experts think you need means inevitably that

1 the procedures and processes that the experts think
2 babies should be getting cannot be done in the way that
3 is intended. Or if it is, it is only being done at the
4 cost of exhausting the staff, probably filling them with
5 that sort of moral dilemma, actually, of: do I carry on
6 doing wrong thing because I've got no choice? And of
7 course the more you stress your staff, the more you
8 overwork them, the more they are likely to have to
9 tolerate things they shouldn't tolerate and the more
10 likely they are of eventually to give up doing the work.
11 So you get into a vicious cycle of people leaving
12 because they can't -- firstly they can't square this
13 moral circle, if you like, that's the wrong analogy, but
14 you know what I mean, any more. So they can't stand it,
15 so they go and do something else.
16 **Q.** And in 2015 the report suggested that two-thirds of
17 neonatal units didn't have sufficient nursing staffing
18 to meet the national guidelines?
19 **A.** Yes.
20 **Q.** So whatever evidence we will hear about the position at
21 the Countess, that was the national picture?
22 **A.** Yes. And it inevitably leads to unsafe practices which
23 are probably unavoidable in the short term. But the
24 issue I suppose may then be: is enough being done to
25 cure that? There has been -- and it is getting better

1 now in terms of planning but until relatively recently
2 strategic planning of staff recruitment -- professional
3 staff recruitment -- has been good because obviously in
4 order to recruit new, more specialist nurses, there is
5 a time lag because you have to recruit people, you have
6 to train them and training for this sort of thing
7 requires a significant period of time.
8 But there are of course -- if you know that there is
9 a shortage of staff then clearly you need to look at
10 what, what do you do to mitigate to reduce the risks
11 that results from that. And that's of course where you
12 would need the neonatal experts to tell you what it is
13 you can do.
14 But the fundamental point is that automation can
15 deal with a lot but actually at the end of the day a lot
16 of care of this nature has to be dealt with face to face
17 by trained human beings and in other industries you stop
18 the activity. If you haven't got sufficient pilots to
19 fly your plane, the plane doesn't take off. If
20 a nuclear power station hasn't got staff in it, it will
21 close.
22 You can't do that with a neonatal unit. Or you
23 might be able to if you have transferred the babies
24 somewhere else but there may be risks about that so this
25 is not an easy thing but it does mean that it should be

1 a very high priority to get your staffing right and of
2 course then you are met with well, we haven't got the
3 money to do it, so where do you take the money from in
4 order to do this, and that's a matter of priority.
5 But the worst thing to do is, going back to the
6 cultural point, to deny this is a problem so you need to
7 accept there is a problem, be honest about it and
8 I believe -- and I speak here as a former Chair of
9 Health Watch England and President of the Patients
10 Association, you must involve the parents in this. You
11 must be honest with them about the fact things aren't as
12 they should be if that's the position. It will worry
13 them, of course, but they have a right to know and
14 a right to for themselves to work out whether what's
15 happening has to happen or not.
16 **Q.** I am going to move on to the next substantial topic,
17 namely safeguarding in the NHS, which is section 6 --
18 **A.** Yes.
19 **Q.** -- of your Part 2 of your report, starting at page 56.
20 And again there may be a relatively short way through
21 this because I think you have had an opportunity to
22 consider at least in part Dr Garstang's evidence?
23 **A.** Yes.
24 **Q.** Now, despite all of your very many interactions with the
25 National Health Service over the course of your career

1 in different ways, do you regard yourself as an expert
2 in safeguarding?
3 **A.** No, I don't, and perhaps surprisingly it's not something
4 that really has cropped up a great deal in the Inquiries
5 that I have done and I am, when I look back at it, a bit
6 surprised about that because safeguarding as a concept
7 is about vulnerable people, it's not just about
8 vulnerable children, although that's clearly a hugely
9 important part of it. But vulnerable adults deserve
10 safeguarding processes as well and it's not something
11 that I therefore have come across a lot.
12 But I have read Dr Garstang's evidence and I am
13 somewhat relieved to find that most of what I had
14 sighted was in her evidence much more thorough than
15 mine.
16 **Q.** What you will have heard about, I have no doubt, over
17 the course of those interactions with National Health
18 Service is patient safety?
19 **A.** Yes.
20 **Q.** Although not an expert, do you think the two are the
21 same thing or do you think that there is a difference
22 between the two concepts?
23 **A.** Between patient safety and --
24 **Q.** And safeguarding.
25 **A.** -- safeguarding? Well, firstly I think safeguarding as

1 a concept is a broader, I mean, patient safety tends to
2 be obviously about the -- the safety of medical
3 treatment and care and the provision of that, whereas
4 safeguarding is about the protection more generally of
5 in this case the child, but actually of that the safety
6 of the patient is but one part of it, so a lot of
7 safeguarding for instance quite properly is about safety
8 in the family and in the home or in the community.
9 So patient safety I would say is part of
10 safeguarding and clearly if one looks at the processes
11 for Child Death Review and so on, if that's happening in
12 a hospital, then the outcome of that is clearly relevant
13 to the learning required to make patients safe or to
14 make the children safe as patients.
15 **Q.** So they are closely related but they are not the same
16 thing, you would say?
17 **A.** Yes, and I would suggest that the fact of for instance
18 a safeguarding investigative process taking place is in
19 itself necessary but it is no substitute for the
20 investigations required from a patient safety angle in
21 terms of learning from an incident about what went
22 wrong, why it went wrong and what lessons there are to
23 be learned.
24 Clearly there can be efforts saved by co-ordination
25 of the two, so lots of people aren't doing the same

1 thing for no good reason but the concepts I think are
2 slightly different -- well, that's all I need say on
3 that.
4 **Q.** Now, under the topic of safeguarding, one matter that Dr
5 Garstang assisted us with but stated in terms it was not
6 an area that she was she would hold herself out as
7 an expert in was medical examiners?
8 **A.** Yes.
9 **Q.** You deal with these at page 62 in your paragraph 6.2.19?
10 **A.** Yes.
11 **Q.** As this is a topic that we are going to return to in
12 Part C, could you just assist us, please, with a summary
13 of what you understand the medical examiner system to be
14 and what its value is as far as you are concerned?
15 **A.** Yes. Well, interestingly it is one of those clearly
16 desirable measures that was included or first I think
17 identified by Dame Janet Smith in the Shipman Inquiry
18 and was part of -- I think it was the 2009 Coroners Act,
19 but has only finally been fully implemented this year,
20 so that tells you how long it takes for a measure which
21 by common consent was a good one to do for patient
22 safety to be fully implemented and I won't go into the
23 history of it. It still hadn't been implemented when
24 I did the Staffordshire Inquiry, there were pilot
25 schemes going, I heard evidence about them at that

1 point.
2 I recommended that it should happen and that was in
3 2013 and literally the Royal College of Pathologists had
4 an event celebrating the final implementation of this
5 last month.
6 So that's how long it has taken. But the idea of
7 the medical examiner is that it is an independent
8 medically qualified person who reviews any death. It is
9 different from -- they -- the idea originally was they
10 should be part of the Coroners service, they have in
11 fact now been employed by the hospitals, not everyone
12 thinks that's the best place for them to be, but that's
13 where they are.
14 They provide, whether the death is in hospital or
15 not, an independent view of two things really: one is
16 whether the death certificate -- whether the cause of
17 death has been established correctly, so they look at
18 that process, and they can in advance provide support to
19 the doctors who were thinking of signing a death
20 certificate as to what the cause of death is.
21 They the second function they perform is they
22 provide a means of communication with the family, the
23 bereaved family of the deceased, asking them whether
24 they have any concerns, which is in shorthand called
25 "the Shipman question" and the idea of that is that it

1 was thought -- found in fact in the Shipman Inquiry that
2 if only people had asked the families of these deceased
3 elderly people information of concern would have come to
4 light which would have lead to a quicker investigation.
5 That's one of the purposes of it but there is also the
6 purpose of providing compassion and support to people at
7 a terrible time, but allows them to participate in
8 whatever process is about to take place.
9 So they provide a safety valve, really, to ensure
10 that deaths are be properly recorded, whether they are
11 being properly referred to the Coroner, and most
12 important in my view whether the family have concerns
13 that they feel ought to be looked into. By reason of
14 that work, because they will deal with the deaths
15 obviously in a particular area, they will develop
16 a systemic knowledge of training and one of the things
17 I found at Mid Staffordshire, much to my surprise, was
18 the Coroners deal with cases of necessity on a one by
19 one basis, that they don't keep figures as to what types
20 of death are occurring, there was no means by which the
21 Staffordshire Coroner would have to detect whether there
22 was an abnormal pattern of death coming out of their
23 hospitals and that's not their job. The medical
24 examiner, it may well be part of their job to do that.
25 So that's the value of them and therefore they are

1 very likely to be -- have the ability to pick up early
2 warning signs of a problem developing in a hospital
3 because they will be dealing with the deaths in the
4 hospital and that's their -- at the moment that's deemed
5 principally what they do but they are now beginning to
6 deal with this in the community as well and so I believe
7 them to be one of the most valuable safety --
8 interventions for safety in every sense of the word that
9 you could have because they are proactive, they are
10 available and without -- they are not -- and I hope they
11 don't become -- a bureaucratic process but they are able
12 to review notes, talk to people and so on in a slightly
13 less formal way than would happen at an inquest.
14 **MR DE LA POER:** Thank you very much.
15 My Lady, would that be a convenient moment?
16 **LADY JUSTICE THIRLWALL:** Yes, certainly, thank you,
17 Mr De La Poer.
18 Sir Robert, we are going to take a break now of
19 about 15 minutes.
20 **THE WITNESS:** Sure.
21 **LADY JUSTICE THIRLWALL:** So if we could all be back, please,
22 by 11.30.
23 **(11.13 am)**
24 **(A short break)**
25 **(11.30 am)**

1 **MR DE LA POER:** Sir Robert, we have two topics just to deal
2 with briefly by way of introduction.
3 You will be asked further questions by Core
4 Participants about each of these in due course, so all
5 that we will do now is just introduce each of these
6 topics. The first topic is whistleblowing/Freedom to
7 Speak Up and of course as you told us at the beginning,
8 you conducted the Freedom to Speak Up Review in 2015.
9 Can you just help us briefly to understand how it
10 was that you came to do that and any headline that came
11 out of that for you at that time?
12 **A.** Yes. Well, following the Mid Staffordshire report, it
13 was apparent from that that certain of the issues at Mid
14 Staffordshire had been about a failure of the
15 organisation to listen to concerns raised by staff on
16 the one hand and on the other the bad treatment of
17 staff, not actually by management, but by colleagues of
18 someone who had raised concerns about not just mistakes
19 but about transgression and I can deal with that in
20 detail, if you want.
21 But because I was dealing with the events of one
22 hospital it wasn't, although many things I was able to
23 look at a national picture that I wasn't, and the then
24 Secretary of State I think felt there was a bit of work
25 to do on the ability of members of staff to speak up

1 when they were concerned about matters and what we
2 basically wanted and also their treatment if they did
3 that.
4 So I was commissioned to review those aspects which
5 were called whistleblowing but actually right at the
6 outset I made it clear to the Secretary of State that
7 I didn't want to do a report called "the whistleblowing
8 review", I wanted to talk about or look into the freedom
9 of staff to speak up which it seemed to me the more
10 positive way of putting it. The reason I did that is
11 that whistleblowing is often thought of as in
12 a pejorative sense, quite wrongly usually, but there is
13 a sort of going right back to the school playground the
14 idea of the sneak who's never been popular and
15 whistleblowing often has a pejorative meaning, often
16 when it shouldn't.
17 So I was -- I undertook a review of how people in
18 the NHS were treated when they and how they were able to
19 speak up and if they did speak up, what happened to them
20 and a very sorry picture emerged. I can go into detail
21 if you want.
22 **Q.** I think for now that is sufficient for our purposes.
23 **A.** Right.
24 **Q.** That's not because it is unimportant but it is because
25 others will be asking you about it.

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1 **A.** Yes.
2 **Q.** So that, if you like, has set the scene for Freedom to
3 Speak Up, which will come this afternoon.
4 The second topic that I am just going to introduce
5 is your section 2 of your Part 2 Report, which you have
6 headed "Openness, Transparency and Candour"?
7 **A.** Yes.
8 **Q.** Again, as I make clear, the level of detail that I am
9 dealing with this is not because it is unimportant but
10 it is because others will deal with that but you provide
11 a definition for each of these three words and I wonder
12 if you can just as this introduction give us the
13 definition. My Lady, it is on page 12 of the Part 2
14 Report.
15 **A.** Yes, well, the openness, transparency and candour are in
16 reality different aspects of the same thing, really, and
17 I suppose openness is the overarching one and I defined
18 it as the proactive provision of information about
19 performance, negative as well as positive. And by that
20 I meant proactive sharing of information internally and
21 externally.
22 In my view, an NHS Trust provider of healthcare is
23 something we all own, we should be entitled as members
24 of the public or as patients or as parents to know
25 what's going on inside this organisation and that

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1 information should be provided willingly and without
2 prevarication.
3 There are of course qualifications to that about
4 personal data, confidentiality and so on which one might
5 go to. But it is the willingness to provide that
6 information. Transparency means -- and my definition
7 was:
8 "The provision of facilities for all interested
9 persons and organisations to see the information they
10 need properly to meet their own legitimate needs in
11 assessing the performance of a provider in the provision
12 of services."
13 So it is one thing for people to be open but you
14 have got to be able to act -- the people who need the
15 information need to be able to access it, so whether it
16 be by way of report, the Internet, answers to enquiries,
17 and so on, the information that the people legitimately
18 need should be provided and so there is an underlying
19 thing about both these things which is of course the
20 information provided must be true, it mustn't be
21 misleading and particularly it mustn't be misleading by
22 omission and a lot of what happened in Mid Staffordshire
23 involved not giving information or putting an inaccurate
24 spin on it, so all -- for instance, classically this was
25 an organisation that told the Regulator it had no

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1 problem with mortality, while at the same time it was
2 challenging the technical accuracy of figures showing it
3 was an outlier in terms of mortality. Those two things
4 just don't fit together.
5 So that's what I mean by open as transparency, it
6 includes that concept.
7 Candour became to have a technical meaning. What
8 I meant by that was, and the definition was:
9 "The volunteering of all relevant information to
10 persons who have [and this is important] or may have
11 been harmed by the provision of services, whether or not
12 the information has been requested, and whether or not
13 a complaint or a report about that provision has been
14 made."
15 So candour in this sense is about being proactively
16 honest with people when something either has -- is known
17 to have gone wrong or might have gone wrong and we don't
18 wait to be asked or for a complaint, we are just honest
19 about it.
20 But that comes under the rubric of being open, it is
21 one aspect of being open and but perhaps one of the most
22 important ones, because it concentrates on the
23 obligation of the organisation to be honest with its
24 individual patients and their families of course.
25 **Q.** That's all I am going to ask you by way of introduction

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1 to that topic, but you have just said it provides
2 a segue into my next topic, which is concerns and
3 complaints by parents and here we need to look at both
4 how things are or how they were?
5 **A.** Yes.
6 **Q.** And then how you would wish them to be?
7 **A.** Yes.
8 **Q.** So we will take it in two parts.
9 The time period that we are focused upon, as you
10 know, Sir Robert, is 2015, 2016, 2017, so we will just
11 consider, please, what the expectations were at that
12 time. This is dealt with by section 7, starting at
13 page 64, of your second part.
14 **A.** Thank you.
15 **Q.** The starting point you identify is a document you have
16 already introduced to us, namely the NHS Constitution?
17 **A.** Yes. Sorry, the answer is yes.
18 **Q.** Yes?
19 **A.** Sorry.
20 **Q.** No, I made a statement. My rising inflection was
21 insufficient.
22 So the NHS Constitution set out that patients have
23 a right:
24 "To have an acknowledgement of their complaint about
25 the service in three working days and to have it

1 properly investigated;
2 "To discuss the manner in which the complaint is to
3 be handled ...
4 "To be kept informed of progress;
5 "To know the outcome of the investigation;
6 "To have an explanation of the conclusions;
7 "To have confirmation of any action to be taken."
8 And to complain to the Ombudsman if not satisfied.
9 So on the face of it, a multi-staged series of
10 rights enshrined in a document under statute?
11 **A.** Yes. And everything that you have read out from the NHS
12 Constitution is founded on some statutory regulations
13 that specifically deal with complaints.
14 Perhaps I might interject, if I may. The
15 question -- the examination question I was set at the
16 top talks about concerns and complaints and what I then
17 answered, to be honest, was really about complaints.
18 There is a -- "concerns" is a rather ambiguous word
19 but it does include, it seems to me, worries that
20 a parent might have or a patient might have about their
21 care which they raise on the ward, not as a complaint
22 but because they are just worried about something and
23 there are mechanisms for dealing with that which
24 I probably haven't dealt with there but for instance
25 every hospital has a Patient Advisory Liaison Service

1 called PALS, and you are meant to be able to go there
2 with your concern and in a well-run place they will sort
3 things out for you, they will find the right person to
4 talk to and so on.
5 But we have also -- and I am sure I have already
6 dealt with this, what led to Martha's Law which is
7 about: I've got a concern, I don't really think the
8 doctor has got it quite right, what do I do? I don't
9 want to make a complaint. That I think was, it's always
10 been people's right to go and get a second opinion but
11 it wasn't well known and it's only sort of now that it's
12 become much clearer, I think, what people's rights are
13 and what can be done about that.
14 But the complaint was really the next stage which is
15 if your concern hadn't been dealt with and complaints
16 are usually something that are retrospective in the
17 sense a treatment stopped, something has happened that
18 you make a complaint and then you get into this
19 statutory process which we might want to look into but
20 it has a habit of becoming quite bureaucratic.
21 **Q.** Well, we will get into it, but we probably should
22 understand the scale of what is being managed which you
23 deal with at 7.7?
24 **A.** Yes.
25 **Q.** You use the word "massive"?

1 **A.** Yes.
2 **Q.** In numerical terms could you just tell us what the
3 number of complaints the NHS received in 2022/2023
4 employees?
5 **A.** Well, so far as I can see, the total was 103,874
6 complaints -- that's in hospital and community
7 services -- of which 27% were upheld.
8 A relatively smaller number of those related to
9 paediatric clinical treatment, namely 2,136. Obviously
10 when I say it was a massive number probably if you
11 divide that down into the number of hospitals it becomes
12 less and somewhat more manageable. But that's -- and
13 also when you consider and I don't know how many
14 millions of medical interventions there are in the NHS
15 every year, but it is tens of millions. So I think it
16 is a relatively small proportion of medical treatment
17 ends up with a complaint. But it is still in absolute
18 terms a large number.
19 **Q.** And you deal at 7.8, that was the position now by
20 reference to the latest data?
21 **A.** Yes.
22 **Q.** That there were by a small number in comparative terms
23 more complaints 2015/2016 across the whole NHS?
24 **A.** Yes.
25 **Q.** So this is plainly, would you agree, a very important

1 part of the NHS functioning?
2 A. Definitely. I mean, I described it before and I will
3 describe it again, this is gold dust. This is not -- it
4 is obviously bad news that someone has felt the need to
5 complain but it is good news that they have in the sense
6 that it is an opportunity for the organisation involved
7 to learn about something that's gone wrong and put it
8 right. And importantly, not only is this about what the
9 complainant has said has gone wrong they may be right or
10 wrong about that but the fact that they have found
11 a need to complain is itself something which they should
12 be able to learn from.
13 Q. So if we look at how things have developed and in
14 particular what was being said just before the period
15 that we are focused on?
16 A. Yes.
17 Q. Your 7.11, you refer to a report about the NHS
18 complaints system which was published in 2013?
19 A. Yes.
20 Q. And what in your view was the main take away that NHS
21 Trusts and Foundation Trusts should have been thinking
22 about following that report?
23 A. Well, they found that I think there was considerable
24 variation in practice across the system and but most
25 importantly, that complaints were not being used to the

1 extent they could be in order to learn lessons from them
2 and to change practice and they tended to be being dealt
3 with in a sort of numerical way, you know, the fewer
4 complaints there were was good news which of course
5 is -- the fact the complaints have increased in number
6 could actually be a good thing. It means people are
7 being encouraged to be frank about things in a way
8 perhaps they weren't before.
9 So you can only measure whether the system is
10 working by looking at what's happened as a result of
11 complaints and whether there is a successful outcome to
12 it. So their recommendations were designed to make, to
13 ensure that complaints reached the right level, they
14 were investigated properly, they were collected together
15 and that the relative -- sorry, the people who needed to
16 know about this, including boards, actually got proper
17 information. One of the things I found was the Mid
18 Staffordshire board hardly got any information about its
19 complaints at all and certainly no information about the
20 content of them and some places there would be
21 a categorisation of complaints, there are official
22 categories, which aren't necessarily hugely helpful.
23 But sometimes I believe people need to look at the
24 detail. It's -- when you see a real case and see what
25 has actually happened, it tells you an awful lot about

1 whether something is going badly wrong in your
2 organisation and you don't need to know there were 10
3 like that; one can be enough. It doesn't mean that
4 a board need to deal or has the time to look at all
5 complaints but I do believe it should every now and then
6 pick one out and examine it in detail but that's really
7 the -- answering your question, in a roundabout way, it
8 was masses of that nature and I think that part
9 included, identified and put together ways of making,
10 doing the thing better and we have seen I put out in
11 paragraph 7.11.1 some of the recommendations that were
12 made.
13 Q. And in terms of the implementation of that, those
14 recommendations, you deal at 7.12, you have looked at
15 the Countess of Chester Quality Account?
16 A. Yes.
17 Q. For the same year. So can you just help us with what
18 the Countess was saying about its own response to that
19 report?
20 A. Yes, I should say that every Trust has produced every
21 year -- I think still does, but certainly did then --
22 what is called a Quality Account which is in effect
23 an annual report on the quality of their performance and
24 this report dealt with a number of reports including the
25 Clwyd Hart Review and said that they were "Just

1 beginning to implement the changes recommended at
2 a local level". I don't think it said much more than
3 that, but that's what was mentioned there.
4 Q. It was at least an acknowledgement --
5 A. Yes.
6 Q. -- in a public-facing document that the fact of the
7 report had been noted, that it had been accepted in
8 principle, and that work had begun?
9 A. Yes. And of course that included if one looks back at
10 7.11.1 the Chief Executive should take personal
11 responsibility for the complaints procedure and sign off
12 the letters, which is a very good way obviously for the
13 Chief Executive to be informed as to what's actually
14 going on in his or her organisation.
15 Q. Based on your experience of the NHS, is there a risk
16 with that, though, that it will become an automated
17 procedure because only one person is having to deal with
18 so many that there isn't time to look at any, or do you
19 think that it's essential that the very top of the
20 organisation should have that complete overview?
21 A. Well, I -- I think like with any system it needs to be
22 applied intelligently and obviously if there is a stream
23 of complaints coming in about the lack of car parking
24 spaces then that can probably be dealt with and believe
25 me that's one of the not surprisingly in some places

1 a constant stream of complaints that can probably be
2 dealt with in a slightly more automatic way than
3 a complaint arising out of somebody who has been
4 actually been harmed and you could say, I think, that
5 when someone has been harmed that arguably avoidably the
6 Chief Executive should take a personal interest.
7 One of the problems at Mid Staffordshire, again
8 harking back to that, was that letters of this nature
9 were drafted not surprisingly for the Chief Executive
10 but which he would sign, frankly without paying much
11 attention to the content to the extent that the letters
12 were -- or one in particular I highlighted was
13 completely insensitive to the feelings of a bereaved
14 parent by suggesting to them that after a satisfactory
15 resolution of the matter, no doubt they would feel able
16 to move on, which wasn't received terribly well, as you
17 might imagine, by the parent.
18 So it does tell you something about the
19 organisation, how much care in every sense of the word
20 the Chief Executive is taking for the people he serves
21 or his organisation serves.
22 **Q.** So we have looked at the volume of complaints, we have
23 looked at recommendations. You summarise at 7.17 on
24 page 69 what the position was in 2015 and in summary,
25 those principles from the NHS Constitution, did they

1 govern the way in which a complaint ought to have been
2 dealt with in 2015?
3 **A.** Well, yes. That's what should happen. But obviously
4 a procedure like that is set out in regulation and in
5 a way it's how that gets implemented that matters as
6 much as the formal compliance with it and I think it
7 would be fair to say having read the Clwyd and Hart
8 report that my own experience that the performance in
9 relation to complaints in treating it as a benefit to
10 the system about something you can genuinely use as
11 a resource to learn from was very variable, it was
12 happening in good places, well-run places, the places
13 that needed it to do that most where there were problems
14 were probably not doing quite so well. It is always the
15 problem when you set out in rules and regulations, which
16 you properly should do, this and that should happen,
17 that busy people then concentrate on making sure the box
18 is ticked rather than the purpose of it is fulfilled.
19 **Q.** So does it come to this: as far as you are aware, in
20 2015 there was a variable level of quality when it came
21 to implementing what was required by the black letter of
22 the rules?
23 **A.** Yes and part of that I think would be that for the
24 complaint system as designed here to be working properly
25 it does need the wholehearted support of the staff and

1 understanding of the frontline staff about what -- the
2 value of this. So in a well-run healthy cultured
3 hospital, staff will be actively encouraging their
4 patients who are worried to make a complaint and think
5 that's a good thing for them to do. Others would treat
6 it as a personal insult and become hostile, not think
7 this was a good thing so that's the -- whether it works
8 or not is not to do so much with whether people have
9 ticked the box of writing the letter about a complaint,
10 it is actually what they have done about it. One of the
11 things you can tell often by looking at a response to
12 a complaint, you can ask yourself: has the letter
13 actually answered the complaint? So often it hasn't
14 answered the points that the poor person complaining has
15 made.
16 **Q.** So that was the position then. If we bring ourselves
17 right up to date, we -- you tell us at 7.22 that as
18 recently as 15 May of this year, the Ombudsman, who as
19 we heard at the outset of this section sits at the very
20 back end of the complaints process as effectively
21 a safety net or a check or a balance on the process
22 that's gone before, has just published new good
23 complaint handling guides for the NHS.
24 Is that something that you have had an opportunity
25 to simply register as having happened or to consider in

1 any detail?
2 **A.** No, he -- he produced this Code of Conduct which has
3 received widespread acceptance but he based it on his
4 findings which I deal with at 7.21 about clinical
5 failings leading to avoidable death and one can really
6 sort of -- one of those points was about failing to be
7 honest when things go wrong but another was a failure to
8 respond to complaints in a timely and compassionate way.
9 Healthwatch England, when I was Chair, had only the
10 year before undertaken a survey of complaints processes
11 and found actually many Trusts were not even complying
12 with the minimal, minimum annual reporting requirements
13 for it. Very few seemed to be collecting figures that
14 allowed you to work out what the complaints were about
15 or what the trends were. I think the Ombudsman's Code,
16 which he in fact I think brought about in conjunction
17 with Healthwatch, although I left Healthwatch by that
18 time, to sort of address some of these inconsistencies.
19 So one would hope that some of this will get better.
20 **Q.** Finally before we leave the topic, you at 7.25 express
21 a personal view and then set out a list of factors that
22 bear upon your opinion. Can you just refresh your ...
23 **A.** Yes, I think I mentioned the first one already which is
24 that first of all you need to have health, front line
25 staff who welcome concerns being raised and I think it

1 is difficult for all of us as human beings to receive
2 complaints easily, particularly if we are professionally
3 self-confident people.
4 But actually we need to learn, maybe we need
5 training in it, to accept that if someone is complaining
6 about something we have done there is probably a reason
7 for it even if we weren't conscious of it. So we need
8 insight. But we need to welcome people raising these
9 things. Complainants -- the ordinary member of the
10 public, I don't mean that in a patronising sense, are
11 often not terribly well-equipped to express things, they
12 need help and support to do this. So you don't
13 necessarily -- I am happy to say you don't necessarily
14 need a lawyer to draft your complaint for you but you
15 need someone to talk to, I think, who can then help you
16 articulate what it is you want to complain about.
17 The next thing is that when a complaint is made, so
18 often there is a sort of knee-jerk reaction to it in the
19 sense of it could be either accepting or rejecting it
20 but actually that any serious complaint needs to be
21 investigated properly and it needs to be investigated by
22 someone with an independent and objective mind and the
23 training to do that. I thought at the time of the Mid
24 Staffordshire Inquiry that serious complaints actually
25 needed an external element to them.

1 I find it odd that we have regulators who go and --
2 the CQC inspect hospitals but they have no role in
3 overseeing the conduct of individual complaints and that
4 could be to do with numbers, but then neither as far as
5 I can see do many of the commissioning bodies. Whether
6 commissioning groups or Primary Care Trusts, very rarely
7 would any of them take up even an interest in conduct of
8 a complaint and yet, being an old-fashioned person, it
9 seems to me if you are paying an organisation to provide
10 a service, you should be taking an intimate interest in
11 seeing whether that service has been properly provided.
12 So I do think there should be an independent element
13 in this and you do need to involve the complainants
14 throughout. What happens at the moment often the
15 complainant makes the formal complaint, they get
16 a letter telling them you will hear from us within
17 a certain timeframe, which is often extended, then there
18 is silence and then they get a letter telling them what
19 the result is, either upholding it, not upholding it or
20 somewhere, somewhere in between; if it's upheld, then
21 accompanied by an apology.
22 But often this process won't actually have addressed
23 what the complainant was really talking about and they
24 haven't been involved in the process of the
25 investigations. They are just told a result and just as

1 we need to be involved as patients or as a family of
2 a child in the formulation of treatment being told how
3 it's going, I don't see why the same thing doesn't apply
4 to the investigation of your complaint. This isn't
5 meant to be an adversarial process.
6 It should be a collaborative process, producing
7 a result that everyone feels has resolved the matter at
8 issue.
9 Then the transparency of the process, I am -- the
10 minimum reporting requirements I don't think at the
11 moment provide sufficient detail for the outsider to
12 understand what the problems are in a particular Trust
13 and that tends to be because the shield of
14 confidentiality is abused, I think in most cases it will
15 be possible to publish much more of the case histories
16 without prejudicing people's right to confidentiality
17 because without that, I don't think you have got the
18 full transparency that would actually motivate people to
19 make the relevant changes.
20 **LADY JUSTICE THIRLWALL:** I'm sorry, Sir Robert, I wanted to
21 check one thing. Did you say the shield of
22 confidentiality is used or abused?
23 **A.** The easiest thing to do is say, well, this is about
24 a treatment of a patient.
25 **LADY JUSTICE THIRLWALL:** Yes.

1 **A.** I can't reveal the details because it might identify the
2 patient. But you can sort of pull back or also it might
3 identify some member of staff.
4 But I believe there is a public interest in knowing
5 as much as you can properly put into the public domain
6 about a complaint and I don't think that you -- most of
7 the time you will be able to do that without identifying
8 either the patient or the members of staff involved, but
9 if there is a particular issue arising out of
10 a particular department about monitoring in it or
11 something like that, at least that amount should be put
12 into the public domain and what's been done about it
13 because that's the most important thing, not that there
14 has been a complaint, it is what has been done to make
15 sure it doesn't happen again.
16 **LADY JUSTICE THIRLWALL:** Thank you.
17 **MR DE LA POER:** So we are going to leave the topic of
18 complaints, although all of these topics that we have
19 covered are really building to this so that we have got
20 the bedrock in place for our next topic, which is the
21 accountability of NHS senior managers.
22 **A.** Yes.
23 **Q.** And you deal with this in sections 9 and 10 of Part 2 of
24 your report. Section 9 begins on page 75 and you begin
25 so that we have got a shared understanding of what we

1 are talking about, providing a definition of "senior
2 manager"?
3 A. Yes.
4 Q. So can you just help us with that, please?
5 A. Well, there are obviously different ways in which one
6 can consider it but I am using the term here as being at
7 a board, the level of the board of the provider, so it
8 would be the Chief Executive but also other Executive or
9 Non-Executive Directors, depending on the type of
10 organisation you are dealing with there might be others
11 just below that, who are -- I mean, a really big Trust,
12 which I don't think this one was, might have several
13 hospitals and they each might have a sort of sub board
14 or an Executive Director in charge of the particular
15 site. They would also I think come within my definition
16 of senior managers. But we are talking about people who
17 aren't -- if I can be respectful, with all due respect,
18 aren't administrators, they are leaders of an
19 organisation.
20 Q. And so in a smaller organisation synonymous with
21 directors but in a very large organisation, potentially
22 those immediately below them?
23 A. Yes.
24 Q. Now, one observation you make early in your answer to
25 the question that was posed to you was to observe what

1 was said in the King's Fund Report about how senior
2 managers are often talked about?
3 A. Mmm.
4 Q. Could you speak to that please --
5 A. Yes.
6 Q. -- and then just give us your own perspective on the
7 fairness or accuracy of that in general terms?
8 A. Yes. With the King's Fund Report, so whenever
9 politicians talk about "management" it is almost
10 invariably a pejorative term and "bureaucrats" is used
11 as well.
12 Of course it is quite wrong because no organisation
13 can run without management and as I think we have
14 already -- I have already indicated, management in this
15 sense is complicated, it is -- there are sciences as
16 well as art in doing it and without it, things will not
17 happen and the mere qualification in this sense of being
18 a doctor, a nurse or a physiotherapist does not equip
19 you to be a manager of this type.
20 And there is -- it's not to say that doctors and
21 nurses do not need leadership qualities, they certainly
22 do, and some of them will become senior managers anyway,
23 but at the level of clinical director, for instance, or
24 matron or senior ward manager in the nursing profession
25 all have elements of this, but the -- no complex

1 organisation like a hospital will run without good
2 managers by which I mean good leaders, really.
3 So I think it is a term which is bandied around and
4 it's easy -- doctors do it as well of course and nurses,
5 they blame the managers, the politicians blame the
6 managers, when actually all they are trying to do is to
7 do an extremely complicated job.
8 Q. And so with that in mind, can you just tell us what the
9 objective is here, in other words good -- accountability
10 of managers is about keeping them accountable to
11 a particular standard?
12 A. Yes.
13 Q. So what is it that makes a good manager? That's a very
14 broad question I recognise, but you deal with it at
15 length and in a number of --
16 A. Yes.
17 Q. -- parts and if you just help us with what -- what is it
18 that managers should be striving for so that we then can
19 work out how to hold them to that standard?
20 A. Yes. Well, as I say, often I think Florence Nightingale
21 put it quite pithily and I quote it here but I just say
22 it:
23 "Let whoever is in charge keep this simple question
24 in her head", she was talking in those days of course,
25 "not how can I always do this right thing myself, but

1 how can I provide for this right thing always to be
2 done?"
3 Within that pithy quotation is actually the essence
4 of what we are talking about. It's actually knowing the
5 first you have got to do is know what is right which is
6 not always easy but you have got to know what is right,
7 and then you have got to ensure that it gets down.
8 That's what a leader is doing and how do you do
9 that? Well, you do that -- firstly you must, your
10 leader must be someone who understands and lives and
11 breathes the appropriate values and I have set out at
12 paragraph 9.15 what some of those are.
13 Q. I mean, I think it would be useful for you just to draw
14 out that list and bring it together for us please?
15 A. Probity obviously goes without saying. We need to be
16 honest, have people who are honest and have the highest
17 level of integrity. They need to be, partly for some of
18 the reasons we have mentioned, they have to have
19 courage. The leader who is unable to confront a senior
20 consultant behaving badly has not got the relevant
21 degree of courage. The leader who cannot bring him or
22 herself to say to NHS England "My organisation is not
23 safe because I haven't got enough money to do X" has not
24 got the right courage. Openness and candour I think we
25 have already dealt with.

But no organisation will have staff in it who are themselves open and candid unless the Chief Executive for instance is also the same. If they see -- the staff see a Chief Executive who denies that things have gone wrong, when they know things have gone wrong, they will not follow that leader or -- and what they will do is they will adopt that leader's habit of denial. So openness and candour is necessary.

No leader is leading in my view properly unless they listen and learn from their patients and from their staff, their colleagues. Good leaders spend very little -- the ones that I have met in the health service spend very little time in their offices behind closed doors. Of course they do spend time there and they spend time in committee meetings and so on, but they are walking the shop floor; they are talking to nurses, they are talking to patients. They are asking people what they would like to see happen or what they think the problems are and of course you might say in a huge organisation they are not going to get round everywhere, of course they are not. But they will be people who go round themselves, their immediate staff will be doing the same. So listening and learning is really important.

The other side of that is by doing that they are

inspiring and motivating their colleagues. They are spreading their method of behaviour, their civility, respect, respectful dealing with people. This is the way we behave, this is -- you are doing a good job, motivation, inspiration come from, from leadership.

They need an ability to create and communicate vision and strategy. Now, that sounds boring in a sense, but -- and it can be done extremely boringly, if you read the vision and strategic statements almost anywhere in the NHS, they won't keep you awake very long. But the purpose of the Chief Executive and the leaders are to communicate the values and the purpose of the strategy and why it matters to people, what is happening, and how it is going to affect people and if they can't do that or get it done, they are not leading effectively.

Of course in a place where -- a service in which resources are never going to be enough, we can never do everything all the time. They need to be able to understand how to prioritise things but -- and to protect patient safety and the provision of the fundamental standards and they must have those standards and the interests of the patient in the case of a hospital always at the forefront of everything they do and they must make sure that everyone in the

organisation does the same.

I have always said that you need to know -- you need to make sure that your finance department has at the front of its mind the interests of the patient, what is the best thing we can do for the patient and you will tend to find that the money then follows -- money problems are then solved. But you need to understand how to prioritise and you need to understand how to protect patient safety in your organisation.

You obviously need a willingness to challenge both internally and externally and, you know, all this means you need the ability to judge and analyse complex issues. Now, as a list of talents to get into one individual I believe that's a pretty demanding list but there are people who can do all that and of course where there are skills that an individual doesn't possess personally you need to have a good team around you to do that.

But if you don't have these values, you will soon find as a leader you are on your own and people aren't talking to you and things are going wrong you don't know about and you will be slowly but surely leading an organisation which is failing.

So that's a list. I mean, lots of people have different lists but that's mine.

Q. So that is the way in which it is to be hoped that senior managers will --

A. Yes.

Q. -- behave. The question then comes, how can the system be designed to ensure that that occurs? We will begin with a historical perspective looking back at 2015 in terms of what was the position back then in terms of the systems that were in place and you deal at 9.22, which is on page 81, with one part of that standard setting/standard keeping, the appraisal process and you tell us at 9.22 although it's not a process that you are directly familiar with in terms of managers, that it is a process generally that you have some understanding of?

A. Yes. Well, I think the position was this: there were a number of framework documents which would set out the expectations for being a manager and to be fair some of that would probably have incorporated the sort of things I have been talking about. So I think there was documentation there which if followed could produce leaders of that nature but as I have said, I think the real problem was not so much the policies as finding the people who embody these values to recruit.

There was remarkably little competition for some of these jobs. So, for instance, at Mid Staffordshire an undoubtedly frankly unsuitable person got the job

1 because there was no one else. I mean the evidence
2 before the Inquiry was frankly explicitly that the
3 person doing the appointment, that's what they felt.
4 So I think that there was a problem then which
5 I think is increasingly being remedied of
6 professional -- a lack of professional development of
7 people in the health service to equip them eventually to
8 take these very, very demanding roles.
9 What some people and a so-called elite almost were
10 occasionally sent off to Harvard Business School or
11 wherever, but generally speaking, people could arrive in
12 these positions with very little training whereas
13 I think now there is a leadership academy and things
14 like that which have helped produce -- none of it seems
15 to be compulsory but it is easier to access the training
16 which you require to become a good leader or at least
17 for people to be tested as to whether they are --
18 whether it has gone far enough I rather doubt, but
19 that's where we are.
20 **Q.** Just considering the appraisal process back in 2015 to
21 the extent that you can assist us, is that a process
22 that you understood was mandatory?
23 **A.** Yes.
24 **Q.** In the sense that it was required that all senior
25 managers were the subject of appraisal or was that

1 something that simply occurred because in hospitals
2 doctors and nurses are regularly appraised and it sort
3 of fed upwards?
4 **A.** No, there was -- board appraisals I think were a common
5 feature by which I mean the Chair would be appraised
6 there is a way of doing that, and I am pretty confident
7 that Chief Executives would be have an annual appraisal
8 from the board. This is different from the clinical
9 governance system which would be to deal with doctors in
10 particular, which has now become rather more
11 sophisticated over the years.
12 But the thing about appraisals, and I have some
13 personal experience of this sitting on boards, that they
14 can be of two types, there is the type where the
15 Chief Executive has a cup of coffee with or lunch with
16 the Chair once a year and they just congratulate each
17 other on how well things are going and there is the
18 appraisal which is much more formal and involves the
19 setting of objectives and assessment of whether last
20 year's objectives have been met, what forms of personal
21 or professional development the individual wants and so
22 on. I think in well-run places that's what happens and
23 therefore is something that's more than a tick box
24 exercise but it is something that produces good value.
25 But I am not sure and I don't know whether that's

1 something that happened everywhere.
2 **Q.** So the --
3 **A.** I would be more confident that it does now than it did
4 then.
5 **Q.** So the appraisal process is one internal mechanism?
6 **A.** Yes.
7 **Q.** By which a senior manager can be held to account?
8 **A.** Yes.
9 **Q.** If, as you have described, it is done in the second way,
10 rather than perhaps the more self-congratulatory way?
11 **A.** Yes.
12 **Q.** Aside from that internal mechanism, in 2015, what is
13 your understanding about the way in which there was any
14 other mechanism to ensure accountability for senior
15 managers?
16 **A.** Well, by then the Care Quality Commission had begun to
17 inspect hospitals, Trusts in particular, and indeed all
18 healthcare providers in a rather more -- I was going to
19 say intrusive way, but that's certainly I think how it
20 felt to them, but to look at the standards being applied
21 in the hospital.
22 Part of that was -- and still is, the most important
23 part of it is an assessment of the leadership of the
24 organisation. So while that might not be directly
25 personal, it would be -- the inspectors would see

1 whether there was effective leadership in a place by
2 looking at how things were being run and they issued
3 reams of guidance of what their expectations are for
4 leadership in a Trust. I used to occasionally go on
5 inspections when I was a director and I have to say
6 I would not have wanted to be the Chief Executive or the
7 Chair being asked the questions that were asked by the
8 inspector, very politely. But, for instance, they would
9 ask the Chief Executive or the Chair what they saw the
10 problem as being in the hospital and they would ask --
11 if there had been a previous report, how have you dealt
12 with the problems you identified then? Then half
13 an hour later we would be at a meeting with the
14 inspector of nurses or doctors and asking them what they
15 thought the current problems were and you would of
16 course get an entirely different list of things, all of
17 which were objectively verifiable and none of which the
18 board seemed to either know about or if they did know
19 about it, they were not intending to tell the CQC about.
20 So that sort of inspection was really holding people
21 to account and of course that tended to lead sometimes
22 to the unfortunate consequence I think of making
23 inspections look punitive because if the report was
24 negative you could end up with the Chief Executive
25 losing their job and -- which I don't think was

1 necessarily the right outcome.
2 **Q.** So just focusing on 2015, 2016?
3 **A.** Yes, what I described then would have been happening
4 then.
5 **Q.** Well, exactly so, that was what I was just going to
6 cover.
7 **A.** But when inspections occurred was dependent on a lot and
8 sometimes there was quite a long time between
9 inspections and that time has now increased much more
10 now.
11 **Q.** So that's a form of external --
12 **A.** Yes.
13 **Q.** -- scrutiny --
14 **A.** I should perhaps add those are routine inspections.
15 Obviously the CQC have the power and did, if serious
16 concerns were raised, they could be prompted to
17 undertake a more immediate risk-based assessment and
18 that could again -- would include looking at the
19 leadership. So it didn't necessarily need to wait for
20 a routine three-yearly visit or whatever it was.
21 **Q.** In terms of NHS England's role in 2015 --
22 **A.** Yes.
23 **Q.** -- what did you understand NHS England could do?
24 I think you deal with this at 10.4 which is on page 84
25 of your report.

1 **A.** Well, yes, the -- as I think I have indicated before,
2 NHS England was the source of the funding for all
3 hospital trusts and there would have been a direct
4 relationship between I would believe NHS England's
5 regional director of the relevant area and the
6 Chief Executive and there would be a pretty constant
7 review of performance and that would -- for in effect
8 all the things that were the responsibility of the
9 Chief Executive who is the accounting officer for the
10 Trust.
11 It would tend to be more, particularly in
12 financially troubled trusts, more about the money
13 I think than it would be about the quality and safety,
14 although there would be different views I think you will
15 find expressed from different people about that. So it
16 might depend on a personal experience.
17 But the pressure, a lot of pressure could be applied
18 and they complained about it in journals, you know, the
19 HSJ and so on, a lot of pressure put on people where the
20 finance wasn't being run to the liking of NHS England
21 and, not surprisingly, therefore, there would be a focus
22 from the Chief Executive on those aspects of their
23 organisation.
24 **Q.** So you have described three different mechanisms for --
25 **A.** Yes, and I should add there, I mean, the direct

1 accountability was there because what various -- we
2 could go into the technical ways in which Chief
3 Executives were hired and fired. But there is no doubt
4 at all that if NHS England thought that the
5 Chief Executive should go, the Chief Executive would go.
6 So that's the accountability.
7 **Q.** So NHS England CQC through their regime of inspections
8 and an internal process, the appraisal --
9 **A.** Yes.
10 **Q.** -- being one aspect --
11 **A.** Yes.
12 **Q.** -- of that?
13 **A.** I mean, the technical, where a Foundation Trust has
14 a board of governors and that who appoint the Chair,
15 I think, but -- but obviously the board of an NHS Trust
16 has a, or a Foundation Trust, would have a role in
17 either of the -- in the dismissal of the Chief Executive
18 as well.
19 But there is a sort of collaboration. In real life
20 there is a collaboration there, but the final word
21 I would say would be held by NHS England.
22 They might correct you if I am wrong about that.
23 **Q.** So three different ways back in 2015, '16 and '17?
24 **A.** Yes.
25 **Q.** Have things changed since then in terms of holding

1 senior managers to account?
2 **A.** I don't think they have, no. But --
3 **Q.** One matter that you mention in your report is the fit
4 and proper person test.
5 **A.** Yes. Well, that was, that was then because it was part
6 of the same regulations as the duty of candour and it's
7 always been problematic I think in how it's been
8 applied.
9 The technicality is that to be a director, you have
10 to be a fit and proper person and it's the
11 responsibility of the organisation of which you are
12 a member to see that you, as a board member you are
13 a fit and proper person both at the time you are
14 appointed and throughout. It -- the CQC is the
15 regulator for enforcing that regulation, but it doesn't
16 actually or hasn't actually ever, as far as I know,
17 investigated an individual as to whether they are a fit
18 and proper person.
19 What they do is assure themselves that there is
20 a process that's been followed to -- to -- so that to
21 ensure people are fit and proper and, frankly, that
22 hasn't worked, and the obvious human problem is that as
23 a chair of an NHS Trust to decide that your
24 Chief Executive is not a fit and proper person is quite
25 difficult; and vice versa, who is -- adjudicates on the

1 chair of the organisation.
2 So it's generally thought now that it is not a very
3 effective way of checking whether people are fit and
4 proper people and to my -- well, in my opinion, there
5 have been some pretty egregious cases recently of
6 evidence where there's been evidence of
7 a Chief Executive, maybe the Chair for instance
8 victimising whistleblowers which, to my mind, raises
9 an issue as to whether they are fit and proper and
10 nothing much happens frankly and the reason, it seems to
11 me, is that there is -- there's no -- if a doctor is
12 thought to be unfit or proper the
13 General Medical Council will investigate, it's
14 an independent body. If it sees fit, it refers a case
15 to the Medical Professional Tribunal Service, which is
16 an independent adjudicator, who decides on the fitness
17 of that person to continue in practice. There is no
18 equivalent for non-clinical managers and you won't be
19 surprised to know I think there should be.
20 But because -- the absence of that means that there
21 is no fair process for deciding these things and of
22 course with all these cases there can be two sides to
23 the story and you need a place where, where those, the
24 issues can be resolved and currently I don't see that
25 there is.

1 **Q.** So that is a change that you think would increase the
2 accountability of senior managers?
3 **A.** Well, it would do, it would do that and it would also
4 put non-clinical leaders and managers on the same
5 footing as their colleagues around the board table.
6 And because I mean the interesting thing is or the
7 sad thing is that if a doctor is brave enough to become
8 a Chief Executive of a Trust and act in a way which is
9 contrary to the patient's interests the GMC can, and
10 occasionally has -- it happened to the Chief Executive
11 of Bristol being hauled up before the
12 General Medical Council for their conduct as the
13 Chief Executive because they will be involved inevitably
14 a breach of the Code of Conduct of a doctor.
15 There is no such, no such procedure for the
16 non-clinical manager and the result I'm afraid is that
17 people who haven't done terribly well, one way or the
18 other, may leave one job. You will then find they crop
19 up in another job because there is no overall
20 certification as to whether someone is a fit and proper
21 person at any given time to do these roles.
22 So I am in favour of there being a system of
23 regulation that at least has that element to it. I
24 mean, there are various forms of regulation you can have
25 but I think there ought to be a means of disqualifying

1 someone from being the chief officer or senior director
2 or a director of an NHS organisation.
3 **Q.** Just advancing this as a lively debate --
4 **A.** It is.
5 **Q.** -- in terms of the pros and cons --
6 **A.** And it's the -- some -- you would expect all, all
7 members of the management classes to oppose this, but
8 interestingly enough they don't or there is a debate
9 about it. A lot of it's about the cost of it, but
10 actually many would actually welcome having the backing
11 of an organisation which gives them a professional
12 status, gives them professional obligations which then
13 shelters them from some of the pressures that they
14 currently face.
15 **Q.** Well, it was on that very point that I was just going to
16 ask you and present the counterargument for your comment
17 that one of the counterarguments is that there may be
18 a chilling effect in circumstances where there perhaps
19 aren't as many good candidates that might be wished for,
20 that good candidates would be deterred by the excessive
21 or the extra layer of scrutiny. But from what you have
22 just said, that isn't your expectation having spoken to
23 those in that position?
24 **A.** Well, the -- they are justifiable complaints about the
25 level of scrutiny that they are under, but frankly the

1 scrutiny might become better organised and fairer and
2 more transparent if there was a system of regulation
3 that I believe for the regulation of doctors protects
4 good doctors. For instance, it allows, it tells them
5 they must be candid and if they are not they might get
6 struck off.
7 So they can go to their employer and say: I had to
8 say this because that's what my professional obligation
9 was. A manager can say that but there is -- but at the
10 moment there's not many teeth, as it were, behind,
11 behind that and I think something to be -- to actually
12 have more of a certification that you are a fit and
13 proper person would actually be a protection.
14 What scrutiny goes behind that is a different issue
15 and there is clearly a debate to be had about whether
16 the CQC or NHS England or whoever are doing too much
17 burden -- overburdening the scrutiny or not. But
18 I think that's a different issue for myself.
19 **Q.** Thank you. Is there any other view that you have in
20 terms of how the accountability of senior managers might
21 be strengthened? I don't detect one, but I wanted to
22 give the opportunity in case I've missed one.
23 **A.** Well, I think I mentioned I think in my original report
24 and I probably didn't say much about it here, was
25 I think there is a place for a greater use of peer

1 review within the system by which -- certainly a lot of
2 that does happen now with royal colleges coming in and
3 reviewing clinical practice.
4 But there is no reason why you can't apply something
5 similar in relation to management processes and so of
6 course the problem we have at the moment is that the CQC
7 will come and examine a place effectively or not, and
8 there is a debate about that at the moment, but say find
9 a need to change. You have got NHS England who will
10 demand that change is made and may suggest things that
11 need to be done.
12 But actually probably what you need is colleagues,
13 trusted colleagues or from somewhere else in the system
14 to come and help you make the changes and suggest ways
15 of doing that. Now, some of that happens
16 institutionally, but one of the burdens that successful
17 Chief Executives in the NHS face is that they are often
18 asked to go and help out, change other places and
19 sometimes the worst thing that happens, and it does
20 happen, if it happens to be a neighbouring Trust they
21 are asked to be Chief Executive of both at the same time
22 so that they hope that the positive things in one place
23 infect the place which isn't working very well.
24 And that, that is -- it sometimes works, it
25 sometimes doesn't. But I think there could be probably

1 more organisation into something less formal than that
2 and of course any good Chief Executive will have
3 a network of support, but I am asking for something
4 a bit more than that.
5 In the nuclear power industry they have a more
6 formalised peer review whereby competitive, competing
7 companies go and inspect the nuclear power facilities in
8 other places and come up with quite critical
9 recommendations, and the reason they do that is that
10 they know even though they are competitors that one
11 nuclear power station failure is a commercial disaster
12 for them all. So they will help each other.
13 I mean, that may not be happening in Eastern Europe
14 at the moment frankly but in the rest of the world it is
15 and apparently, according to the people I have spoken to
16 and seen evidence of, it works very well. You could
17 organise something like that in the NHS but, you know,
18 that's not a formal system of accountability but it is
19 more something of support for people in very challenging
20 circumstances.
21 **Q.** Thank you. Now, the final topic that I intended to deal
22 with before lunch was effective management in the NHS,
23 but you have already dealt very substantially --
24 **A.** Sorry.
25 **Q.** No, that's not you, that's me.

1 **LADY JUSTICE THIRLWALL:** No one is complaining.
2 **MR DE LA POER:** It certainly wasn't meant in a critical way.
3 So there is just one facet of it that you deal with in
4 your section 12 that I don't think that we have looked
5 at closely, your section 12 starting at 87, and this is
6 just considering that interface between senior
7 management and staff, the lines of communication and
8 what may be thought from your very substantial review of
9 a large number of public inquiries and investigations
10 a perennial problem.
11 So if we could just start by summarising if you
12 would for us, please, what sort of issues have been
13 identified historically with communication breakdown
14 between senior managers and staff?
15 **A.** Well, as I indicate here, going back as far as 1969, the
16 then Mr Jeffrey Howe found in a place where there was
17 corruption and abuse that staff had been persuaded that
18 there was no point in complaining and that is a constant
19 feature of so many of these inquiries particularly when
20 I looked at it in this way dealing with what was called
21 last week transgressive behaviour; that there's
22 a feeling there is no point in complaining because
23 nothing will happen.
24 We may come to it later when I am asked about it,
25 but the Freedom to Speak Up agenda is not just about

1 speaking up. It's about listening and action in
2 relation to the concerns raised and if you don't have
3 that bit people stop complaining, they stop raising
4 concerns and so that seems to have been, it seems
5 through Shipman and I think the HSSIB Report, Airedale
6 and certainly at Mid Staffordshire, where staff found it
7 was -- there was no point in complaining about staffing
8 being unsafe as a cause of an incident because nothing
9 ever happened about it and indeed they were encouraged
10 not to use that.
11 So there is this sort of blockage of information
12 that's caused by culture. Sometimes it's more than
13 culture, it's actually more deliberate than that.
14 But we can -- I mean again at Mid Staffordshire
15 a nurse who raised concerns about the fabrication of
16 medical records, discharge times in the casualty
17 department, was sought to be discouraged by physical
18 threats from her colleagues and -- that wasn't the
19 management but that just shows how bad culture, culture
20 can get.
21 So communication is really important. Recognising
22 that barriers like this can occur in subunits of your
23 bigger unit, your leadership needs to be able to get --
24 demonstrate that that's not -- it is not true that you
25 don't want to hear about these things and you need to

1 communicate that by, well, one is actually physical
2 presence and talking to people but obviously there are
3 a need to be other means to do that as well and that
4 needs to be a two-way process. You need to communicate.
5 I mean if I go back to the nuclear power point
6 again. A Chief Executive of a nuclear power station
7 told me -- a power company -- that he would when he
8 talked to engineers or whatever on his visits he would
9 ask them if there was any concern. He would be told of
10 a concern and he would make it his business within
11 a short time to have sent an email back to that
12 individual with what he found out about that concern and
13 what he was going to do about it. He wouldn't
14 necessarily agree with it but there would be that
15 communication.
16 That's a simple way of doing it. There obviously
17 needs to be more complex ways as well. But the point is
18 you need the message to get through that the senior
19 leadership wants to know about this stuff and is going
20 to congratulate you for telling us, thank you and not
21 beat you up for it.
22 **Q.** How important do you view that positive acknowledgement
23 as being part of the way to --
24 **A.** It is absolutely vital. Obviously it is quite difficult
25 to arrange in some cases in the sense that ideally you

1 want not only the individual who has given you the
2 information to be congratulated, you want everyone else
3 to know about this as well because then it encourages
4 others to behave in the same way.
5 Clearly sometimes the issues are too delicate or,
6 you know, if you are trying to assure the safety of the
7 person who is giving you the information you may find
8 that more difficult but -- and indeed I found in the
9 Freedom to Speak Up Review one of the difficulties was
10 actually finding the good practice, the good stories
11 because they were too confidential for that reason. Or
12 actually the other reason was it was so much a matter of
13 normal practice no one actually knew that it was
14 necessarily something to brag about.
15 But you do need to brag about these things and
16 I have always thought for instance the Care Quality
17 Commission could do more because when it receives
18 information, as it does about concerns, it will often go
19 and take action about them. I don't think it does
20 enough to celebrate the fact that a member of staff
21 somewhere has been brave enough to tell them whatever it
22 was which has led to a positive change in a hospital.
23 But you do need that to happen.
24 **MR DE LA POER:** Thank you very much indeed.
25 I have one more substantial topic, namely

1 recommendations by previous NHS inquiries to deal with.
2 My Lady, I wonder whether now might be a convenient
3 moment rather than breaking it, although I can make
4 a start. Entirely in my Lady's gift.
5 **LADY JUSTICE THIRLWALL:** It is entirely a matter for you,
6 Mr de La Poer.
7 **MR DE LA POER:** Could I ask then that we break for an hour
8 for lunch now?
9 **LADY JUSTICE THIRLWALL:** Yes.
10 **MR DE LA POER:** And resume with that topic which we will
11 deal with as a piece.
12 **LADY JUSTICE THIRLWALL:** Is that convenient to you?
13 **A.** Yes, certainly.
14 **LADY JUSTICE THIRLWALL:** So we will rise now and come back
15 at a quarter to 2.
16 **(12.44 pm)**
17 **(The lunch break)**
18 **(1.44 pm)**
19 **MR DE LA POER:** Sir Robert, my final topic of any substance
20 in terms of length is recommendations by previous NHS
21 Inquiries, investigations and reviews.
22 You devote Part 1 of your report to this topic and
23 of course appendix 4, which I am not going to invite you
24 to turn up, deals with it in even greater detail and all
25 of that will stand as part of the Inquiry's record.

1 The first thing that I wanted to ask you about is
2 what you say on page 3 of Part 1 in the final paragraph?
3 **A.** Yes.
4 **Q.** Now, you were asked by the Inquiry to consider whether
5 or not particular recommendations had been implemented
6 and you tell us in that paragraph that this was not
7 a straightforward process and I wonder if you could just
8 elaborate on the challenge that you found the task of
9 just working out whether in the case of any particular
10 Inquiry, in any particular recommendation within that
11 Inquiry, it had in fact been implemented?
12 **A.** Well, an Inquiry will make recommendations. It will
13 usually say who it thinks is responsible for
14 implementing them. It's usually addressed -- the report
15 is usually addressed of a Public Inquiry to the
16 Government who issue usually issue a response. Not
17 always, but usually. Frankly, one of the most dangerous
18 words to see in a Government response to an Inquiry
19 recommendation is that it welcomes it.
20 I don't say that completely in jest but almost
21 invariably governments have a habit of accepting
22 recommendations, in principle at least, and then after
23 that it becomes quite difficult to establish precisely
24 what has happened.
25 With my Inquiry I made a recommendation that the

1 Health Select Committee at the House of Commons should
2 be invited to in effect monitor the response to the
3 recommendations and I believe that had a positive
4 effect. The Government very properly and notably
5 actually did not one but two formal responses to my
6 regrettably large number of recommendations, 290 in my
7 case, but they did respond to all of them, not once but
8 twice in different reports and the Health Select
9 Committee reviewed the matter I think on two occasions,
10 it may have been more.
11 I did also recommend that NHS Trusts should in their
12 annual reports annually say what they were doing about
13 the recommendations.
14 I confess not to have done an exhaustive survey of
15 what happened about that, but I know that some did, for
16 a time at least, and the reason I did that was that not
17 all my recommendations required action by the
18 Government. Some of them were matters that I hoped
19 would be taken into account in normal every day practice
20 near the front line.
21 But following -- so that was two or three years in.
22 After that, it becomes increasingly difficult to work
23 out what has happened for a number of reasons. If
24 people stop or organisations stop reporting what they
25 are doing about it, you then have to go into -- delve

1 into quite a forensic research to find out.
2 Secondly, I was reporting into an environment in
3 which what we now call for shorthand the Lansley Reforms
4 were being implemented, so the organisations to which
5 recommendations were addressed were changing and so that
6 makes it difficult as well.
7 I think another problem is -- moving back from my
8 own Inquiry to more general is that it is often observed
9 that one Inquiry makes relatively similar
10 recommendations to another, sometimes with a different
11 emphasis because times have changed, but almost
12 invariably in different words and those charged with
13 implementing recommendations then have a really
14 difficult job because they then have to match different
15 recommendations and different phrases together, try and
16 group them and make sense out of it and I think to be
17 fair, that can often be very difficult.
18 So looking back at it, I would suggest that perhaps
19 people like myself who were asked to make
20 recommendations probably need a bit more discipline and
21 maybe guidance actually in the way we actually formulate
22 recommendations.
23 So I think it can be difficult to follow through
24 over a period of years and some recommendations it is
25 very easy: either a Freedom to Speak Up Guardian has

1 been appointed or it hasn't, that's sort of relatively
2 easy. But the more generic ones of changing culture are
3 more difficult to audit and it is an area which I have
4 given a bit of thought to over the years and I think
5 there are some improvements that could be made to make
6 better use of recommendations, if I can put it that way.
7 **Q.** Well, on that topic, can I just invite you to consider
8 this analysis of what you said in your report about what
9 makes a good recommendation --
10 **A.** Yes.
11 **Q.** -- and the challenges to making a good recommendation.
12 The first one you have already spoken to which is the
13 continuous systemic and structural change that's
14 occurring presents a challenge that must be overcome?
15 **A.** Yes.
16 **Q.** The second is already referred to that there are
17 overlapping recommendations.
18 The third is about how well focused the
19 recommendations are and allied to that how easy it can
20 be to measure whether or not they have been implemented .
21 The fourth I think you have referred to this morning
22 about people taking guidance from the top who are in
23 senior management positions, that it is very difficult
24 to change culture through a recommendation coming in the
25 front door if everybody is looking upward.

1 **A.** Yes.
2 **Q.** And the fifth challenge that you identify in your report
3 is about silo thinking. That's not something that we
4 have touched on yet. Can you just help us to understand
5 how silo thinking can affect the recommendation process?
6 **A.** Well, there is a tendency, understandable in human
7 terms, that an Inquiry report comes out about the Mid
8 Staffordshire NHS Foundation NHS Trust, dare I say it
9 the Countess of Chester Hospital, Airedale, wherever it
10 is and the busy Chief Executive in Cornwall -- don't
11 take, it is nothing personal about Cornwall, it could be
12 anywhere -- thinks: oh well, it is nothing to do with me
13 or alternatively if it is, someone will tell me about
14 it.
15 That's understandable because we all, I'm afraid,
16 write reports of a certain length, they all have
17 Executive summaries, but in real life a Chief Executive
18 of another Trust has not got time to digest all these
19 things.
20 I can't tell you how often after the Mid
21 Staffordshire Inquiry I was asked by different people in
22 very senior positions that: wasn't that a one-off case?
23 I would have to tell them, no, the recommendations --
24 and I am talking about senior Ministers and the like,
25 people senior in the NHS, who were seeking to comfort

1 themselves with the thought that this was only about
2 Mid Staffordshire. So there is a communications aspect
3 I think about the applicability of things.
4 Then also even at the level of specialty,
5 Mid Staffordshire was a different issue because it did
6 cover the whole hospital in a way, but even so, for
7 instance a general surgeon might be thinking about, say,
8 a case of an obstetrician's misconduct, that it had
9 nothing to do with them.
10 So there is a sort of various silos, there are
11 different -- the NHS healthcare system is made up of
12 lots of different communities, professional communities
13 and others, and they tend to look only at things that
14 come over the wall because they are to do with them.
15 So I think it is important, looking back on it --
16 and I criticise myself as much as I might others -- that
17 we need to think more carefully about to whom we address
18 recommendations, how -- to whom we say they apply which
19 is possibly different from who's got to implement it and
20 also put things in a way which makes it -- people
21 understand a bit more about how -- what they are meant
22 to do.
23 I should say in my defence that when I was drafting
24 or thinking about recommendations, I actually appointed
25 a panel of experts informally and in private, to review

1 what I was proposing to say and the task I gave them was
2 could you tell me whether this is practical, is this
3 something that -- I am not asking whether you agree with
4 it or not, but is it something that could be implemented
5 or is it so impractical that it wouldn't be able to
6 happen and I found that very valuable and I did make
7 changes as a result of that sort of advice.
8 What I tried to avoid was any form of negotiation
9 with those commissioning the Inquiry about it. I was --
10 and again I say this without criticism, of course it was
11 meant with the best of intentions, I was offered help on
12 more than one occasion if I need any assistance in this
13 regard, please let them know and the answer was: thank
14 you very much, I don't need that assistance, I am
15 an independent Inquiry.
16 But there is something about ensuring
17 recommendations are implementable, if that's a word, and
18 ensuring that that happens that I don't think we have
19 quite got into the Inquiry process yet and there are of
20 course I think probably various different ways in which
21 one could try to do that.
22 **Q.** Well, one perhaps very recent example that I know you
23 have had an opportunity to consider is a publication by
24 HSSIB, "Recommendations But No Action", a publication
25 I think of the last two weeks?

1 **A.** Yes.
2 **Q.** Have you had a chance to --
3 **A.** Yes, I have seen that.
4 **Q.** -- have a look at that?
5 **A.** Yes.
6 **Q.** And also in parallel with that, you were asked to look
7 at Dr Benneyworth's witness statement?
8 **A.** Which I'm afraid I couldn't do because I couldn't access
9 it. I'm afraid I have not seen that.
10 **Q.** Well, let's see how we get on with the report itself.
11 In summary, do you agree with all of what it is saying,
12 some of what it is saying or do you have reservations?
13 **A.** I think the principles there are absolutely correct.
14 The idea of Registers of Recommendations are good.
15 I'm afraid I can't remember where, they did refer to
16 NHS England having produced a register of I think
17 recommendations actually in the paediatric field.
18 **Q.** I think it was in maternity services?
19 **A.** Maternity services, I am grateful, thank you. I did
20 look at that and it is -- one attempt ironically got me
21 to a page which said there wasn't a page but I did
22 eventually get to a page which had it and I thought it
23 demonstrated actually the challenge because what the
24 spreadsheet did was to -- rather as in fact the
25 spreadsheet given to me for this Inquiry, it set out the

1 recommendation, a lot of text, who was meant to be
2 implementing it and then not a lot else. The trouble is
3 a lot of the text of these recommendations doesn't leave
4 you with a very clear idea what is required.
5 So a lot of recommendations are for instance to
6 focus, give more focus to a particular value or culture.
7 It doesn't really help you very much in deciding whether
8 that's happened or not and I think that more, in
9 addition to recording that there is a recommendation
10 about something, particularly where there are numbers
11 saying something similar, I'm afraid some analysis needs
12 to be done by somebody to bring, consolidate them and
13 turn that into what are the actions required and of
14 course that has a lot of challenges.
15 But I think a lot of this would be simplified if, if
16 Inquiries were asked not to -- if they were going to
17 endorse a recommendation made by a previous Inquiry is
18 maybe to change it, if that's necessary for a new
19 context, but not just make a new recommendation because
20 I think that makes the executive's life very difficult
21 looking back at it.
22 **Q.** So that's a practical solution to the problem that
23 presented itself to you when you looked at --
24 **A.** Yes.
25 **Q.** -- this attempt to create what I think the HSSIB

1 describes as a searchable repository of recommendations?
2 **A.** Yes, yes. Because it is a, not a criticism but I do
3 welcome that, it's a start.
4 **Q.** When it comes to the formulation of recommendations, how
5 important is it that they are narrowly focused or is it
6 overly reductionist to come up with a hard and fast rule
7 like that?
8 **A.** I think it is pretty case-specific. I mean, if you are
9 talking about culture generally you probably need some
10 overarching themes and objectives but also which I did
11 try not necessarily successfully to do, to suggest at
12 least some practical ways in which one could assist in
13 a change of culture but I think it's often important in
14 addition to looking at a recommendation to actually
15 bother to look at the text as to the explanation for
16 what's behind the recommendation because that often
17 brings to life what the problem was that the
18 recommendation is seeking to solve and therefore makes
19 it easier to see what it is that's meant -- intended to
20 happen.
21 But I don't think you can say all recommendations
22 must be specific because sometimes frankly the Inquiry
23 is not equipped to do more than say this is the problem,
24 this needs to change, maybe you need a different method
25 to decide what to do about it so the specifics, putting

1 it in a contradictory way, can sometimes need to be
2 quite general. I don't think you can have a rule about
3 that.
4 **Q.** You have touched on this already in terms of the silo
5 thinking and the obstetrician in Cornwall becoming aware
6 of the cardiologist in Leeds and whether one is really
7 looking at the other. Very many previous investigations
8 have been focused on a particular disaster or event or
9 person and the recommendations necessarily are developed
10 by reference to that scenario.
11 **A.** Yes.
12 **Q.** How is that potential problem or challenge to be
13 addressed in terms of the formulation of recommendations
14 by which I mean should the person making the
15 recommendation be consciously trying to apply it
16 holistically or is it just an inevitable part of the
17 Inquiry process that is always going to be generated by
18 particular facts and it is then for others to derive
19 value from it?
20 **A.** Well, I think there is a danger if you require all
21 Inquiries to be holistic in the way you describe to turn
22 every Inquiry into a sort of Royal Commission on the
23 health service or the transport system or whatever is
24 the subject.
25 The principal purpose of an Inquiry which arises out

1 of a disaster has, I'm afraid, to be about that disaster
2 and if it is about an individual, that's where you
3 start. But I do think it's important that Inquiries of
4 that nature do take into account the wider context. It
5 was sometimes said -- frankly, I think unfairly, but it
6 was sometimes said of the Shipman Inquiry that it made
7 recommendations relevant to the general health service
8 on the back of an extraordinarily rare incident and
9 therefore was potentially a disproportionate response to
10 that. Personally I disagree with that because I think
11 that Dame Janet actually explained pretty well what the
12 general lessons were to be learned out of that dreadful
13 tragedy.
14 But I think it is possible to seek to make general
15 propositions about what -- how the systems should change
16 to cure what actually is an individualistic problem but
17 that doesn't mean that that is -- I mean sometimes
18 that's necessary, I'm afraid. You are dealing -- if you
19 are dealing with very rare but extremely serious events,
20 then the system needs a means of coping with that,
21 albeit without doing so at the expense of preventing for
22 instance care being given to lots of decent people by
23 other decent professionals.
24 **Q.** I just have two specific matters to draw to your
25 attention and then we are going to have a look at

1 a number of recommendations that have been made in the
2 past and seek your comments about it.
3 The first is in the first part of your report,
4 please, and it is to be found on page 64, which --
5 **A.** I am there.
6 **Q.** You are there.
7 **A.** Yes.
8 **Q.** Here just to provide some context, we are dealing with
9 recommendations you made in Mid Staffordshire Public
10 Inquiry and in particular at 8.11.1, your
11 Recommendations 57 and 58, to encourage CQC to involve
12 patients and representatives of the healthcare
13 professions in the work of CQC?
14 **A.** Yes.
15 **Q.** So that's the headline recommendation.
16 **A.** Yes.
17 **Q.** The question I have is about your (g) and in particular
18 the final sentence in it where you say:
19 "It is likely, in my view, that CQC could do more to
20 involve staff and valuable information they hold in its
21 regulatory activity and to provide them with meaningful
22 feedback about the action taken on that information."
23 The question really is: can you expand upon the
24 practical ways in which you envisage the CQC could do
25 that?

1 A. What I had in mind there was that -- and I observed this
2 in part of the CQC -- the organisation would receive
3 increasingly encouragingly larger numbers of pieces of
4 information from staff about concerns that they had and
5 the process would be that the CQC would then decide what
6 to do with that piece of information, sometimes they
7 would log it as part of the genuine intelligence,
8 sometimes it was at one end, at the other end it would
9 be serious enough to undertake an immediate inspection.
10 Usually there would be no -- after the additional
11 piece of information had come through there would be no
12 further real contact with the individual who had
13 provided the information. There might be some
14 acknowledgement. But possibly, you know, "your
15 information is important to us" type of communication
16 without much else happening. I think the people who
17 take the trouble sometimes at risk to themselves of
18 providing information to the organisation ought to be
19 more closely involved in what happens next and told what
20 their part in it has been. So that would be one way of
21 involving people.
22 So people should be getting feedback about what has
23 happened as a result of their information. Sometimes
24 you can't, it is difficult, obviously if it is anonymous
25 you can't do it directly. But even if it is anonymous

1 you can by a general broadcast, "We received information
2 from staff" sort of communication, because I think it is
3 only in that way that the positive effect of making this
4 sort of -- raising this sort of concern is encouraged.
5 So -- and also the other point about it is this:
6 I think there should be -- once someone has come forward
7 with information in good faith about a public concern of
8 this nature, public interest concern, I believe not
9 necessarily in a legal sense but a duty, a moral duty of
10 care arises in relation to that individual and if they,
11 the organisation CQC whoever it is, should be ensuring
12 that those people who give the information are not
13 suffering a detriment as a result.
14 I think many people who raise these concerns can
15 feel a bit deserted, not being looked after and they
16 deserve to be looked after because they have done a good
17 thing. So for both the reason -- and also sometimes
18 information gets misunderstood. So if you don't have
19 a continuing conversation about it, you don't see that
20 either.
21 So for those reasons, I think there should be a much
22 more personal contact with the informant in these
23 circumstances.
24 Q. Thank you.
25 Can I ask you to advance to page 82, which I think

1 is internal page 81.
2 A. Yes.
3 Q. Here, dealing with openness, transparency and candour
4 and your Recommendations 173-184.
5 A. Yes.
6 Q. The question relates as I say to internal page 81 and
7 letter (j).
8 A. Yes.
9 Q. It's really around the topic of whether or not the duty
10 of candour is in your view being complied with and
11 whether or not that there is anything the CQC should be
12 doing in relation to that?
13 A. Well, it's always been part of the CQC's remit to be the
14 regulator overseeing the compliance with Regulation 20
15 which is the duty of candour regulation. So it's always
16 been, or should have been, part of what they look at
17 when they go and inspect a provider.
18 I think that has been a little bit variable in how
19 it's being done, I couldn't give you an analysis of that
20 but that would be my impression. Certainly it is only
21 fairly recently that they appear to have started using
22 their powers to prosecute for non-compliance or to levy
23 some form of penalty. So the accountability behind that
24 has only been recently coming in and the understandable
25 reason to begin with would be this is a new duty, it

1 takes time to embed things and what you want to see is
2 things being developed rather than deterring people,
3 punishing people prematurely about this.
4 But I think that there has I think developed
5 a feeling that it's not working as well as it should do
6 and I think my theory is really this: the regulation
7 inevitably sets out what is a bureaucratic process, it
8 involves a bureaucratic process, but as I think I said
9 before, that's the beginning of what you have to do, it
10 is by no means the purpose of it or the end and
11 I'm afraid there's a sort of phrase that does the rounds
12 a little bit of "doing candour", which is sort of "we
13 have got a process to do".
14 But anecdotally, I hear of worrying things.
15 Thinking of one case I heard about a doctor having made
16 a mistake on a patient which caused some harm, not in
17 the end life-threatening but it shouldn't have happened,
18 and wanted to meet the patient about it, was told they
19 couldn't and we need to look into this and so on, which
20 was fine. But then presented with a letter to send
21 which was fulfil the obligations of candour, but the
22 doctor concerned said, "I can't send a letter like that,
23 it will upset them even more, I want to explain this, it
24 is complicated stuff". "No, you can't do that". So was
25 made to send a draft letter which wasn't incorrect but

1 was sort of in tones which it was predicted by the
2 doctor would upset the patient and indeed did, so went
3 on the warpath. So again said "I want to have a meeting
4 with the patient" and in this case family and it was
5 only when the temperature had got really very high and
6 lawyers had been involved that, oh, they finally agreed
7 "you can have a meeting".
8 But, you know, the whole thing had become: we have
9 a process and we have to follow this, rather than
10 allowing it to be clinically led by a perfectly honest
11 doctor trying to do their best to be candid and to
12 support the patient about something that had happened
13 and somehow or another the actual process had got in the
14 way of a human interaction which caused much less
15 distress all round. So there is something about
16 processes in the NHS which sometimes gets in the way of
17 the intention and I think there is a bit of that.
18 There is a feeling also that some of the
19 bureaucratic requirements are burdensome and there would
20 be a better way of doing it and that's undoubtedly the
21 case. So I welcome the fact of the review because
22 I think now we have got years of experience of this and
23 there may well be improvements to be made in how this is
24 all done.
25 **Q.** Do you think that the focus by providers is more in

1 relation to the notifiable safety incident requirement
2 of Regulation 22 rather than the general requirement
3 under 21?
4 **A.** I suspect that's correct. I mean, the notifiable
5 incident system is to be welcomed. It is much more
6 I think sensitive to patient safety issues than it
7 probably was. But I think sometimes it is forgotten
8 that the overarching obligation is about openness and
9 transparency of which candour and notification are
10 an important part, but not the only part.
11 The most important part is looking after your
12 patient and their family, where appropriate the family
13 and their concerns. And the process as such is still
14 I think treated -- the process of the duty of candour
15 has been treated as a defensive mechanism rather than an
16 involvement mechanism and a resolution mechanism. The
17 whole point of the duty of candour is to satisfy people
18 who have been harmed or might have been harmed, giving
19 them an opportunity to understand what has happened, and
20 to take part in the process of improvement, to receive
21 redress by way of apology and if necessary some money,
22 but all without having to bother lawyers or the courts
23 or disciplinary processes but to actually do things
24 quickly and resolve them quickly and allow people to
25 feel that they have been respected all those things and

1 it doesn't happen if you have -- the instinct is well,
2 I am doing by the duty of candour is producing
3 a defensive position. You have got to start from the
4 position that: I am being candid because it is the right
5 thing to do for my patient.
6 **Q.** Turn now to look at some recommendations that have been
7 made previously and these have been drawn to your
8 attention. Some are covered by your Part 1 report?
9 **A.** Yes.
10 **Q.** Others appear in the appendix, but we are going to be
11 focused here. Under the heading of "Institutional
12 Memory" you of course have dealt with this in your
13 Part 1 report, the Clothier Inquiry, Recommendation 13.
14 I will just read it out:
15 "[The Grantham disaster] should serve to heighten
16 awareness in all those caring for children of the
17 possibility of malevolent intervention as a cause of
18 unexplained clinical events."
19 That Recommendation was made in 1994.
20 **A.** Yes.
21 **Q.** Now, while your Inquiries, as you have told us, were not
22 focused upon neonatal services, what are you able to say
23 about your understanding of the implementation of this
24 particular recommendation?
25 **A.** Well, I think what it was saying was if there has been

1 no explanation you must -- in these important and sad
2 circumstances, you must seek it. You should never take
3 for granted or take -- accept, as it were, that
4 something is unexplained unless really you have gone as
5 far as you can to explain it. There needs to be an
6 institutional curiosity to sort things out as opposed to
7 accept the thinking or getting away with thinking: this
8 is just one of those things, it's unavoidable. Things
9 are not -- very few things in hindsight are unavoidable
10 if you know what it is you can put right about them.
11 So has that been -- I mean, in one sense you could
12 say that all recommendations on safety and
13 investigations that have been made since then and
14 potentially implemented are an implementation of that
15 but I suspect what has sometimes been missing is that
16 drive to be curious about why something has happened
17 and, you know, it is very easy for busy people to
18 justify well, it is one of those things, there are
19 always unavoidable complications and so on.
20 It is true that some complications are known risks
21 of procedures, that's one thing. But equally that
22 doesn't mean they are not avoidable. It doesn't mean
23 that with some different practice you couldn't change
24 them and, I mean, when it involves death or potentially
25 serious transgressions short of death then it seems to

1 me you shouldn't just be satisfied that someone is
2 saying "I can't prove that this happened", you need to
3 look at the risks and you need to examine how those
4 risks could be mitigated. You should never accept
5 because -- treatment we know doesn't always work, but
6 you shouldn't accept that it must cause harm without
7 knowing why it's caused harm and whether that was part
8 of the risk that you would reasonably expect to be --
9 happen in some part of the treatment, but also in most
10 cases if that's the risk, then people should have been
11 warned about it before anyway.
12 So it's about knowledge and it's about never being
13 satisfied with not knowing. If there will always be
14 unknowables but you should push the -- you shouldn't
15 just abandon the exercise of trying to find out what
16 happened.
17 **Q.** In terms of the recommendation itself, bearing in mind
18 that it is framed in terms of heightening awareness,
19 might this be an example of a recommendation that it's
20 quite difficult to monitor in terms of numbers or do you
21 think it is possible to measure?
22 **A.** I mean, it depends. What with the reporting system that
23 developed and is more sophisticated now, but has over
24 the years, it's always been I think possible to identify
25 trends. So it is possible to notice that -- I mean,

1 obviously it is easier on the national basis than
2 a local basis with rare events, that in certain types of
3 cases, certain events seem to be happening, so why is
4 that and what can we do about it?
5 So I think you can heighten awareness in having
6 a sufficiently detailed reporting system that allows
7 things like this to surface. But that's very difficult
8 I think for extremely rare events on a national basis,
9 less so perhaps if they are local, they are not so rare
10 as they should be.
11 **Q.** Well, the awareness is directed to the minds of those
12 who are caring for children and one way of testing
13 whether that is successful is how frequently when the
14 possibility arises people's minds turn to it as
15 an explanation and how many people just don't think of
16 it?
17 **A.** Yes.
18 **Q.** Is that a fair way of assessing the success of the
19 implementation of that particular recommendation?
20 **A.** I -- the -- the space or the issues around children and
21 deaths sadly have always been an extremely sensitive
22 area and if we go back to -- you have heard something
23 about this last week -- the Sudden Infant Deaths in
24 Infancy or Children, Sudden Unexpected Death in Infancy
25 or Childhood, the sort of fear that many of these were

1 due to perpetrators when in fact as it turned out many
2 of them had a clinical explanation is a classic example
3 I think of an area where real curiosity, not accepting
4 nostrums, as it were, eventually produced an answer
5 which wasn't what people thought in the first place.
6 So I think, I think in a specialist area with
7 specialist journals and so on, case reporting of that
8 nature can keep these things in peoples' minds and if
9 this is done in a culture which puts safety first, then
10 people will be, one hopes, thinking more about the risks
11 of particular things happening rather than just: can we
12 prove it happened?
13 **Q.** The second topic covered by two recommendations made in
14 Dame Janet's third report, I will read them out for you
15 just so that you don't need to turn them up I know you
16 will be familiar with them:
17 "Many of the functions currently carried out by the
18 Coroners require the exercise of medical judgement.
19 Some of those functions require legal expertise. In the
20 future those functions should be carried out by
21 a Medical Coroner and a Judicial Coroner."
22 Secondly:
23 "All deaths should be reported to the Coroner
24 Service which would take responsibility for the
25 certification of a death and for deciding whether

1 further investigation was necessary.
2 "Deaths where the doctor had expressed an opinion as
3 to the cause of death would be considered for
4 certification by the Coroner's Investigator after
5 consultation with the deceased family. All other deaths
6 would go for further investigation by the Medical
7 Coroner".
8 So that is Recommendations 5 and 18.
9 On this same topic, your Recommendation 278:
10 "It should be a routine part of an independent
11 Medical Examiner's role to seek out and consider any
12 serious untoward incidents or adverse incident reports
13 relating to the deceased to ensure that all
14 circumstances are taken into account whether or not
15 referred to in the medical records."
16 Finally on this topic, and I apologise for the
17 amount of information I am giving you here, but I am
18 sure you have seen these before, two from Morecambe Bay:
19 "Steps should be taken to implement the system based
20 on Medical Examiners without delay."
21 Secondly:
22 "Given the systemic review of deaths by Medical
23 Examiners should be in place, this system should be
24 extended to stillbirths as well as neonatal deaths."
25 So that's a series of recommendations all driving in

1 the same direction. No doubt you would say an example
2 of different reports saying very similar things about
3 what needs to happen. Can you just speak to us, please,
4 about the -- I know you have already spoken about
5 Medical Examiners -- importance of those recommendations
6 and your opinion about the speed with which it has been
7 implemented and any explanation that you perceive for
8 any barriers?
9 **A.** Well, they all did speak in the same way. Dame Janet's
10 recommendations she started with about Coroners I don't
11 think were implemented and I don't think they have been.
12 But the -- in effect the Medical Examiner would be, and
13 which I think she recommended as well, to my mind as an
14 adequate substitute, because if independent, properly
15 resourced, doing the job properly and so on, because you
16 have an expert there, a qualified doctor, who is able to
17 monitor, as it were, the certification of the causes of
18 death, is able to gain an impression about patterns that
19 might be happening in a particular place and can talk --
20 most importantly can talk to families, so it has always
21 been an important thing to do and recognised as such.
22 I have followed the progress or otherwise of this
23 recommendation over the years because occasionally
24 I have been asked by the Royal College of Pathologists
25 to assist in the process and as is often the case my

1 take on it would be that it became delayed because of
2 resource implications: it is obviously expensive,
3 potentially expensive, you need to pay someone and
4 employ someone to do this.
5 There were territorial arguments, if you like,
6 between the local authority organisations who it was
7 originally intended should fund the Medical Examiner
8 because they fund the Coroner system. In the end that
9 hasn't happened, not surprisingly local authorities as
10 is well known are extremely short of resources.
11 So it is now something that's had to come out of the
12 NHS budget and it has resulted in Medical Examiners
13 being employed by the main hospital I think in a given
14 area. To my mind, that still has a disadvantage
15 potentially which is that the Medical Examiner is
16 examining the causes of death in an institution in which
17 they are employed.
18 Doctors are 99% of the time people with great
19 integrity and independence and will give an independent
20 view whoever they are employed by and that certainly
21 seems to be the case so far.
22 But with that caveat, we have pretty well got to
23 where Dame Janet and I and Dr Kirkup had said 10 years
24 ago should have happened. It should not have taken that
25 length of time but that's a political matter, all to do

1 with finding the money to do something, and that is
2 often the reason for delay which is someone somewhere
3 has to decide what to prioritise.
4 But in the meantime, it would be fair to say there
5 were any number of pilot projects, I heard evidence of
6 the pilot project in Sheffield which continually
7 demonstrated that the system worked and it brought value
8 and it brought particular comfort to bereaved families.
9 **Q.** The fourth topic "Encouraging or mandating the reporting
10 of concerns in hospitals" and here we have two
11 recommendations from the Bristol Royal Infirmary Public
12 Inquiry. It is not one that we have touched on in any
13 great detail, I am not intending to put you on the spot
14 here but could you just give us a short summary of what
15 the purpose of that Inquiry was?
16 **A.** The?
17 **Q.** The purpose the Bristol Royal Infirmary Inquiry?
18 **A.** Yes, certainly. It arose out of apparently excess
19 number of deaths of babies who were undergoing
20 paediatric -- obviously paediatric heart surgery at the
21 Bristol Royal Infirmary and a failure by that department
22 and the Trust around it to respond to that excess of
23 mortality, despite being informed about it and being
24 given figures about it by a whistleblowing consultant
25 anaesthetist in particular. What was found to be

1 an issue was that basically, well, the Medical Director
2 was the head of the cardio team and therefore when
3 reports were being made was judging his own calls,
4 frankly, and needless to say he didn't think he -- there
5 was anything to be objected to about this.
6 So there was what Professor Kennedy said was a "club
7 culture" which was basically a mutual reassurance
8 between professionals that they weren't doing anything
9 wrong, a categorisation of whistleblower as being
10 a maverick and someone not to be disregarded, and
11 a Chief Executive who I confess I represented at both
12 the General Medical Council and at the Inquiry, who
13 believed what he was told and did nothing more about it.
14 So that was the story.
15 But the underlying recommendations, I think, in
16 terms of reporting were that if you reported deaths, and
17 this was in fact happening, but if you report
18 outcomes -- putting it more widely, you report outcomes
19 from particular types of procedure you develop
20 a knowledge and understanding about what the
21 complications are, what the expected outcomes are and
22 you begin to see pretty quickly whether those
23 organisations but also individuals are in any way out of
24 line with the norm. Of course no one is precisely
25 average and there has to be an acceptable range.

My view was that so far as possible, and some disciplines do this, that actually individual statistics should be available and I have to say if you want -- I have done this myself, if you are thinking of having a hip operation you can actually go online and put the surgeon's name and you will find out how many hip operations they have done in the last year and they will actually at the very small print tell you about any mortality, which of course with hip operations, touch wood, is quite small.

But you can do this without actually threatening the world and provide transparency and you -- if you have this -- you lift the veil a bit, there is a much greater and wider understanding of why something, as paediatric heart surgery must be, very difficult, very challenging, but it can be done.

Q. The two particular recommendations to draw to your attention very much in the vein that you have been speaking about Recommendation 117 and Recommendation 118. First:

"There should be a stipulation in every healthcare professional's contract that sentinel events must be reported, that reporting can be confidential and that reporting within a specified period of time will not attract disciplinary action."

Second:

"The process of reporting of sentinel events should be integrated into every Trust's internal communications, induction training and other staff training. Staff must know what is expected of them, to whom to report and what systems are in place to enable them to report."

A. I absolutely agree with that and I would suggest that that's in effect a necessary sub structure for the duty of candour to be exercised. But it is all part in the case of the professional, their existing professional duty of candour to reporting that somewhere must be an essential part of that.

Q. I am just going to park one word there, "confidential" and I will come back to that in a moment. But just to conclude with two more recommendations.

The first from you in the Mid Staffordshire Public Inquiry. Your Recommendation 36. I will just read it out:

"A coordinated collection of accurate information about the performance of organisations must be available to providers, Commissioners, regulators and the public in as near realtime as possible and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics

about outcomes, it must take advantage of all safety-related information, including that capable of being derived from incidents, complaints and investigations."

So that very much what you have been telling us about --

A. Yes.

Q. -- the Bristol Royal Infirmary Inquiry and moving forward in time to your own Inquiry?

A. Yes, I mean, it may be that it sounds rather ambitious for everything you have said to be put in one place and it probably is. My vision really, and we have got bits of that, but probably not the whole of it, is that we currently have a system whereby hospitals, for instance, are given -- controversially now -- a one-word rating from "outstanding" through to "inadequate". I have always said that actually what I am interested in as a member of the public is what's going on in the department of gastric surgery if I am going in for a gastric operation or my wife is going to have a baby, what's their performance in terms of obstetrics?

What the relevant information is might differ, but there should be available as near realtime as possible, certainly to regulators and people who have the ability to intervene, information that tells them pretty quickly

whether things are going right or wrong. Part of the problem with most data collection is that the results of it come out a year later, which is too late. In that time, people may have died who needn't have died and the data of that nature can often be dismissed by saying "that was last year's data, it was an exceptional year, we have done much better this year".

So you need something better than that. The public may not need realtime in quite that form, but they you should have -- they should be able to access the performance in whatever way it is fair to judge that performance of each department. CQC, if you delve down to their reports, give a rating, but that's not quite the same thing. It is actually I think what people want to know is in A&E how many people get readmitted after being discharged within 30 days, in terms of babies one would like to know what the outcomes are for babies who have been born; there are all sorts of different ways of doing it.

A lot of this is not a question of inventing new data, it is a question of using the existing data that already must be being collected, if only for the purposes of the hospital getting paid for what it does, this data is there. It is a question of how you collect it, put it together and how you disseminate it.

1 Q. The final topic is guidance on how to respond to
2 suspicions of criminal activity and here this is
3 paragraph 2.72 of the Committee of Inquiry Independent
4 Investigation into how the NHS handle the allegations
5 about the conduct of Clifford Ayling, and I will just
6 read out the recommendation:
7 "Strategic Health Authorities should work together
8 with the Department of Health to produce guidance for
9 Primary Care Trusts and other NHS Trusts in the handling
10 of incidents involving potential criminal activity."
11 That was dated 2004.
12 Now, your Inquiries haven't had as their focus
13 criminal activity, but what you do have very great
14 expertise in is understanding the importance of giving
15 people clear guidance to follow in a single place when
16 they are presented with a difficult situation and I am
17 sure that you can, from your position of authority,
18 endorse the idea that suspicions of criminal activity
19 are exactly the sort of situation that requires a clear
20 set of guidance for people to follow?
21 A. I think that's right. By definition thankfully,
22 criminal activity of the type which harms patients
23 directly is very rare. Fraud regrettably less so, but
24 we are not dealing with that. It is the stuff that
25 harms patients and because it is rare people will be

1 uncertain about what to do. It's also extremely
2 worrying, as you heard last week, to actually raise that
3 potential issue that a colleague may be committing
4 a crime and so there does need to be a clear process
5 which can be followed to guide people as to what they
6 should do and what the consequences of them doing it
7 are. Obviously bearing in mind everything we have said
8 it must be a system which makes it clear that raising
9 a concern of that serious nature obviously needs to be
10 done in good faith but you -- it doesn't matter if you
11 turn out to be wrong, you are raising something that
12 requires investigation and you are entitled and indeed
13 it is your duty to do that. But then people need to
14 know what to do after that and naturally it is probably
15 a protocol that needs to be agreed, not only within the
16 health service, but also with other agencies. You know,
17 something similar to the Child Death Review, you need
18 a multi-agency response and you need to know whether you
19 should be reporting to the police or whether if you do
20 report it to the police you can be carrying on some
21 other investigation of your own and so on. These are
22 all difficult issues and often time is at a premium in
23 doing the right thing quickly.
24 So absolutely, you need clear guidance which needs
25 a little bit of training but it also needs to be

1 sufficiently clear that even if you are untrained, you
2 can pick it off the internet or wherever and use it.
3 So, you know, a little like the sort -- of it was
4 mentioned I think last week, the sort of checklist
5 a pilot would have to deal with a crisis. Checklists do
6 work in emergencies much as they do in less certain
7 situations.
8 Q. Thank you, Sir Robert, that's all that I am going to ask
9 you about the implementation of recommendations.
10 I just turn very briefly now to the topic of
11 recommendations for this Inquiry and obviously we are at
12 a very early stage now not having heard any of the
13 factual evidence?
14 A. No.
15 Q. You have put down some of your thoughts in your report
16 and that will speak for itself. There is just one
17 matter that I just wanted to seek your assistance on and
18 then we will conclude with just going back really to
19 where we started.
20 The matter for your assistance is this: in other
21 walks of life, there are confidential reporting systems
22 where people can anonymously raise concerns, sometimes
23 even very serious concerns, which are then logged
24 centrally with an organisation or person who can then
25 have oversight of the patterns and one report about an

1 individual for example or about a particular event may
2 just be noted, but if a pattern develops -- the same
3 individual, for example, is coming up in confidential
4 report after confidential report -- then the
5 organisation is on notice to do something.
6 So this is slightly different perhaps to the Freedom
7 to Speak Up, which will happen more overtly. Is that
8 a system that you could see working for the NHS if it
9 were carefully circumscribed so we are not talking about
10 necessarily clinical concerns, we are talking about
11 concern about criminal activity, for example, that if
12 you put it in that box and said: this is a hotline if
13 you are concerned about criminal activity which you can
14 engage with confidentially, is that something that you
15 think might be something worth looking at?
16 A. Exactly. I believe actually I certainly know some
17 hospital in the private -- independent sector that do
18 just that and personally I would not limit it to,
19 I would use it as something alongside your Freedom to
20 Speak Up policy. We have talked about guardians and
21 I am very keen on everywhere having guardians. But
22 there is also a place for having an external agency to
23 which people can go entirely confidentially.
24 One would like to think that the regulator would be
25 sufficient but it may not be, so -- and if one is

talking about sensitive issues whether they be crime as in harm to patients or sexual misconduct and harassment and bullying, all of that would benefit from having an external place that you can go to, either anonymously or not to record your issue.

I would like to think that it needs to be an outsourced place which has a clinical and professional understanding and expertise within it. I don't think it's sufficient just to have a place where you have got a call handler who is unqualified to take a record of what they are being told. You do need some judgment applied there.

But I think that you are quite right that it is possible, actually particularly probably experience shows in cases of sexual misconduct, that sort of thing, but I would say also actual perpetrators harming patients that the name cropping up more than once, twice, three times from different sources is in itself an indicator of risk and therefore it could and probably would bring sort of an earlier notice of a problem to light.

What of course happens when -- I mean indeed it's a similar system that has been thought about for the judiciary, even, so if it works for the judiciary I don't see why it doesn't work for the health service.

Q. I said we were going to finish largely where we began. One of the very first things you told us about was the proliferation of regulators or bodies which have a regulatory function. Is it your view that that number needs to come down and, if so, and this is a big question, how might that be achieved?

A. As a first step -- I am going to avoid the question slightly. As a first step it would be helpful if the existing plethora of professional regulators coordinated for more with each other in their activities, and by that I mean starting with the guidance. They all have their different codes of conduct. A lot of them are saying much the same things. Obviously when you get down to some of the detail you apply it differently because of the different types of work people do.

But I think you need to develop a common -- after all everyone who is a healthcare worker should be espousing to the same values, the same standards of conduct and so on. Why do you need -- and I say this slightly rhetorically, I think there are about 10 different codes of conduct for the different types of person working in the health service. There should be an overarching one which of course descends eventually to the different duties a physiotherapist might have from a heart surgeon but you can consolidate a lot of

it.

I also think that you should consolidate the adjudication process for bringing professionals -- healthcare professionals to account. At the moment, a doctor is dealt with by one tribunal, a nurse whose conduct may give rise to a question on precisely the same incident is dealt with by a different one. The physiotherapist a third.

There should be in my view just one tribunal service that deals with them all and the reason for that is you could deal with incidents together, you avoid families having to go through multiple processes which often produce inconsistent results. So why not do something like that as a starter? We do have a Professional Standards Authority which seeks to coordinate all this and that may be a start.

I think we could do with a system regulator that actually deals with them personally -- this is a little more controversial perhaps than what I have just said, but I will say it -- with not only the quality of safety but also the finance. The quality and safety should have priority, but financial regulation and the conduct of it should be something capable of regulation separately. At the moment NHS England has become in effect the financial regulator as well as the

commissioner and I am not sure that's going to work very well.

But I think the -- around the outside I think it is easier to co-ordinate the activities of these people, to make them organisations, to produce the same or coordinated sets of guidance than it is to merge them all together. I think if you do that first then you could see whether merging is actually possible.

There is always a danger that reorganising things disrupts things too much and actually leaves holes in the system but -- so I think that's the way I would do it. But the problem is not so much the numbers, it's actually that they all act without collaborating. They all try to collaborate, but they don't collaborate sufficiently in my view.

MR DE LA POER: Thank you, Sir Robert. Those are the questions that I have for you at this time.

My Lady, there are permissions for Core Participants but before I turn to them can I check with my Lady whether you have any questions for Sir Robert at this time?

Questioned by LADY JUSTICE THIRLWALL

LADY JUSTICE THIRLWALL: Yes, Sir Robert, just a couple from me, if I may.

Firstly, you have educated us very comprehensively

1 in a number of issues. I was particularly interested in
2 your view of the Fit and Proper Person Test and how
3 effective it is in really assuring quality in Chief
4 Executives in particular and you gave a list of
5 qualities that you would look for in a good
6 Chief Executive and rightly said at the end of it you
7 would be looking for those in someone to run a FTSE 100
8 company.
9 So what you are looking for, then, is the sort of
10 tip-top leader who has an ethos of public service and is
11 prepared to work at different rates from that which they
12 might expect to get in a FTSE 100 company. From what
13 you say there are a very few people like that running
14 big Hospital Trusts at the moment, have I understood
15 that correctly?
16 **A.** Yes, I hasten to add I am not saying that they lack all
17 these qualities. I would like to think they all have
18 integrity, probity and so on.
19 **LADY JUSTICE THIRLWALL:** Of course, yes.
20 **A.** But some of the skills perhaps they would like support
21 with.
22 **LADY JUSTICE THIRLWALL:** Yes, understood.
23 Then you described -- I don't think you described
24 them as a cohort, but there are those who are just
25 really not up to the job --

1 **A.** Yes.
2 **LADY JUSTICE THIRLWALL:** -- from what you have observed and
3 whilst I can see that leadership courses and training
4 and support might improve things, it occurred to me that
5 by the time someone is in a position to apply to be
6 a Chief Executive, it may be that it is very difficult
7 to turn them into the sort of person that you require if
8 you recruit someone who is not actually up to it in the
9 first place.
10 Is that fair enough?
11 **A.** I think that could be right, my Lady. I think that two
12 routes to becoming a Chief Executive, the rare route is
13 for someone from outside the health service to come in
14 with the experience of complexity elsewhere. There is
15 a debate about whether that's good or not but the
16 reality is most people are going to come up to theses
17 roles via a career in the National Health Service and
18 therefore because of that, if you start the professional
19 development at an early enough stage, people should --
20 this is how the police work or other authorities, you
21 should be able to develop people with skills.
22 My -- I recommended that there should actually be
23 a training college, rather similar to what the police
24 have.
25 **LADY JUSTICE THIRLWALL:** Yes.

1 **A.** Or possibly in the judicial colleges is a version of
2 this, that where you bring together the people who are
3 potential candidates for these higher positions long
4 before they get there --
5 **LADY JUSTICE THIRLWALL:** Yes.
6 **A.** -- and give them intensive training which at the same
7 time allows you to assess their competence, how good
8 they are with teamwork, their behaviours and so on and
9 my observation of how the police do it, I mean obviously
10 the police like every other organisation doesn't always
11 do terribly well but this method of training allows you
12 to see or allow the authorities to see who is going to
13 make the grade or not and also gives people the
14 opportunity to get there and provide them with the
15 equipment to do it.
16 We do have -- I mean there is a leadership college
17 as such but it's not run -- it's actually run by
18 a Hospital Trust Partnership. There is a leadership
19 academy which provides training but there is nothing
20 quite -- so there is lots of training around but I think
21 that this more intensive focus on this group by -- as
22 a more residential and assessment approach would produce
23 candidates who would -- more certainly than we have at
24 the moment. So I would look at something along those
25 lines.

1 But -- and if you can't find the people, well, then
2 you need to actually change -- you need to have a better
3 system of collective leadership maybe bringing bodies
4 together sufficiently so they can actually have as the
5 leader that the one person who can deal with the
6 complexity.
7 But I don't think the situation is yet -- it is
8 better than it was because there is much more training
9 available, there is much more guidance and support. But
10 it is -- it is still a job where there is a very high
11 risk of failure.
12 **LADY JUSTICE THIRLWALL:** Yes, and there is then the
13 merry-go-round of people moving from one institution to
14 the other.
15 **A.** Yes.
16 **LADY JUSTICE THIRLWALL:** Yes. Thank you.
17 You mentioned that you had read the evidence of
18 Professor Dixon-Woods on Friday?
19 **A.** Yes.
20 **LADY JUSTICE THIRLWALL:** And one of the points she made, and
21 I would like to know whether you agree with it, is that
22 when you are looking at culture, that what comes from
23 the centre, as she described it, politicians, DHSC,
24 NHSE, has a very serious impact on the culture and in
25 the boardroom and then indeed on the ward; is that

1 something you agree with?
2 A. Yes, I -- that was the story of Mid Staffordshire and it
3 continues to be the story. I mean, understandably and
4 rightly, politicians and the people in the centre are
5 acutely sensitive to being seen to be on top of things
6 that are going wrong and I'm afraid the easy lever to
7 pull is to blame the Chief Executive and unfortunately
8 that produces the very culture of fear at that level
9 that we are trying to avoid at the lower level.
10 So I'm afraid this does start at the top and how you
11 change that I think is very difficult but I increasingly
12 believe that it brings in focus the absolutely essential
13 need for organisations to start from the bottom by which
14 is you involve your services or your patients and your
15 staff in creating the environment that allows you to do
16 your business effectively and you basically have an
17 organisation that's actually listening to and responding
18 to your staff more frankly than you are mandates from on
19 high.
20 If you -- because then you have got people
21 responding to the information about what's happening at
22 the front line, what the needs of your community are and
23 you involve them and you have a common consensus about
24 how to deal with these problems, whereas if you deal
25 with everything on the basis of a budget coming down

1 from on high, then you will get the problems that we
2 have. I know I will be accused of oversimplification,
3 and it is, but the current system does mean that the
4 pressures coming from down are felt extremely heavily by
5 the time you get down to the Chief Executive and even
6 more further down the hierarchy.
7 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,
8 Sir Robert.
9 Now, is this a good time to take a short break?
10 **MR DE LA POER:** My Lady, I would suggest it is.
11 **LADY JUSTICE THIRLWALL:** Yes. Very good. We will start
12 again at quarter past 3.
13 **(2.57 pm)**
14 **(A short break)**
15 **(3.15 pm)**
16 **LADY JUSTICE THIRLWALL:** Mr Kennedy, is it you now?
17 **MR KENNEDY:** My Lady it is.
18 **LADY JUSTICE THIRLWALL:** The floor is yours.
19 **Questioned by MR KENNEDY**
20 **MR KENNEDY:** Thank you very much.
21 Sir Robert, my name is Andrew Kennedy I appear on
22 behalf of the Countess of Chester Hospital.
23 I have just a few questions really following on from
24 Mr De La Poer's last question to you and it relates to
25 this idea or the concept of collaboration and

1 co-ordination between the higher level bodies and
2 I wanted to ask you the same question that he asked you
3 but in relation to guidance and I had in mind as you set
4 out in chapter or Part 6 of the second part of your
5 report, Chapter 6 of the second part of your report, the
6 various guidance that you identified that was relevant
7 to safeguarding and I am conscious of what you said
8 about your expertise in safeguarding and I am equally
9 conscious of the point that you make that you and
10 Dr Garstang appear to have identified the same guidance.
11 But what one can see is that there is high level
12 guidance from the Department, from NHS England, from the
13 CQC, and from the Royal College amongst others. There
14 will then, I am sure you will be aware, be potentially
15 guidance at a regional level, guidance at a local level
16 and then guidance at a Trust level and so my question
17 is: what can we do to assist the clinician on the ground
18 at the coalface with navigating his or her way through
19 that multiplicity of guidance?
20 A. Well, recalling how long it took me to find it and,
21 I mean, I know I am not a pediatrician, I am not
22 a specialist in the field but then a lot of people who
23 might be in the position of wanting to know about this
24 would probably have to do the exercise I did, and more
25 because, as you say, I didn't penetrate down into the

1 regional and local guidance, no one has who has got
2 a front line job will have time to do that.
3 Well, the first thing is it must be the
4 responsibility of that person's employer to -- if we
5 have got a current system, to have simplified all that
6 into something which could be used at their front line
7 which requires in itself a degree of expertise and
8 understanding of all that has gone on and actually is
9 a job that shouldn't have to be replicated by every
10 single administration in the country.
11 Clearly there will be local things that need to be
12 known that are only relevant in the area like who do
13 you -- who the relevant pediatrician is to speak to,
14 what the phone number is for the review panel or
15 whatever. But it can't be beyond the ability of
16 a system such as the NHS to produce one set of guidance
17 that is applied everywhere, with a page at the back
18 which has whatever you need to know about locally and
19 where I think there is a particular challenge and it is
20 not only in this field is that you will have guidance
21 from, say, the National Health Service itself or the
22 Department of Health and you will have the Royal College
23 guidance which might either precede or come after the
24 other guidance and frankly I think there does need to be
25 a decision made about whose guidance you are meant to

1 follow. The point is none of it probably contradicts
2 with each other but if you have to spend your time
3 reading all this, you will get lost.
4 So I would suggest that as a rule of thumb on issues
5 as important as this that things should be condensed by
6 agreement if possible but if not, by someone taking the
7 decision that this is the guidance, this is what you
8 have to do and at the end of the day, it needs to be
9 reduced to a pretty simple sheet of bullet point
10 actions, albeit there needs to be in the background
11 training, it is sufficient for people who understand the
12 importance of what -- of this particular area and that's
13 the way I would deal with it.
14 **Q.** So it is co-ordination and collaboration at the levels
15 --
16 **A.** Yes.
17 **Q.** -- of those bodies who are currently promulgating the
18 guidance?
19 **A.** Can I add to that that it is in itself a compromise of
20 safety for different places to have different guidance
21 because the NHS is full of staff, particularly medical
22 trainees, who move from one place to the other on
23 a regular basis.
24 And at the moment -- and I don't know about this
25 particular area, but in some areas like surgical

1 procedures they find themselves dealing with an entirely
2 different procedure in every place they go to. That is
3 a compromise of safety.
4 **Q.** And it risks?
5 **A.** Yes.
6 **Q.** It risks concerns falling through gaps?
7 **A.** Yes, exactly.
8 **Q.** Okay. It would also need to make clear what I think you
9 and Dr Garstang accept is not clear from the current
10 safeguarding guidance: that it applies wherever the
11 death occurs, so there's a tendency to believe that
12 safeguarding -- as you recognise in your report that
13 safeguarding relates to events that happen outside
14 hospital?
15 **A.** Yes.
16 **Q.** And it would need to make it clear that it covers
17 safeguarding deaths wherever they might occur?
18 **A.** Yes, I think there are two things: one was that and
19 I think, to be fair, my reading of the guidance,
20 inexpert though it is, is that it has become a bit
21 clearer than it was that it involves hospital deaths as
22 well. But the other thing, which I found probably more
23 concerning, actually, was the fact that the review would
24 be taking place in the home patch, wherever the patient
25 comes from, rather than the place where the incident has

1 occurred.
2 I am not saying it shouldn't be reviewed in the
3 place where the individual has come from, clearly that
4 may be appropriate. But if it is in relation to
5 a hospital incident, then surely a review should be
6 taking place there.
7 **Q.** Yes, my Lady heard some evidence from Dr Garstang about
8 that on Thursday.
9 **A.** Yes.
10 **Q.** It may be that's something that we can come back to.
11 **A.** Yes.
12 **Q.** Just following on from that, the idea of perhaps
13 centralised guidance, and just going to some comments
14 you made at the beginning of Part 2 of your report, so
15 I am on your page 10, and this is a section I don't
16 think we have looked at but at 1.15, so it is --
17 **A.** Yes.
18 **Q.** -- page 11 of relativity. So one at the foot of the
19 page at 1.15 you are talking here about a Reform report
20 and we can find your comment about that earlier.
21 But at 1 -- and you cite from the Reform report and
22 the identified two key pathologies, as they put it, and
23 then they set them out in that passage that you have
24 quoted from.
25 You say at 1.16:

1 "While agreeing with that observation I would add
2 that the 'top down' structure makes it more difficult
3 for recommendations for cultural and other forms of
4 change to be implemented at local level because of the
5 constant pressure on and focus on the requirements of
6 the centre."
7 My question is this: is there a tension between that
8 observation and what we have just been discussing about
9 centralised guidance?
10 **A.** No, I don't think so. Because what you have been asking
11 me about is a system for reporting something. The
12 cultural culture behind that is a different matter. The
13 culture is a willingness on the part of people locally
14 to do the right thing in relation to reporting.
15 I mean, if you take an example of centralised
16 guidance, NICE will lay down in its clinical guidance
17 what the criteria are for giving a particular type of
18 treatment in a particular way and that is guidance which
19 is applied directly or should be applied directly in the
20 units where that treatment is provided.
21 But the compassion, the involvement of patients, the
22 cultural issue round that is more likely to be dealt
23 with locally.
24 So I don't think there -- there can be a tension,
25 granted, but it seems to me that on something as

1 universal as the requirement to report and review the
2 death of a vulnerable child, that there is no reason for
3 the structure of that reporting not to be the same
4 everywhere and actually if you do that, then actually
5 you have comparable figures coming from everywhere. And
6 the culture that goes behind that is a different matter.
7 **Q.** I appreciate the culture is a different matter and the
8 example of the National Institute of Clinical Excellence
9 is a helpful one --
10 **A.** Yes.
11 **Q.** -- where you have centralised decision-making and
12 guidance --
13 **A.** Yes.
14 **Q.** -- which is influencing an outward-looking provision of
15 healthcare at a local level?
16 **A.** I mean, there are other initiatives which are
17 centralised and it is mentioned in various reports,
18 evidence in fact of Professor Dixon-Wood of the Getting
19 it Right First Time programme which is doing something
20 centrally. But by comparing what everyone is doing,
21 putting that together and then pointing out to the
22 outliers: you are doing something different, why are you
23 doing it differently?
24 That's a different form of centralisation but it
25 actually arises out of good practice everywhere and

1 learning from each other, so you could call that top
2 down but it is actually receiving stuff at the front
3 line and then digesting it.
4 **Q.** Yes, and ultimately it is beneficial --
5 **A.** And there is no reason for the guidance you produce
6 about Child Death Reviews not to have a similar thing.
7 The Royal College and others will collect together good
8 practice, the learning and the expertise, it should then
9 be condensed into whatever the appropriate practical
10 guidance is and then disseminated as one thing.
11 **Q.** So in short, there isn't a tension?
12 **A.** Well.
13 **Q.** Not in this example --
14 **A.** You need to be aware of the potential for there being
15 a tension but I think in this, it is resolvable in an
16 instance like that?
17 **MR KENNEDY:** Sir Robert, thank you. My Lady, thank you.
18 Those are my only questions.
19 **LADY JUSTICE THIRLWALL:** Thank you very much, Mr Kennedy.
20 Mr Baker.
21 **Questioned by MR BAKER**
22 **MR BAKER:** Thank you, Sir Robert, I am Richard Baker, I ask
23 questions on behalf of two of the Family Groups.
24 I am going to ask you some questions about candour.
25 So if we could go to the section of your statement that

1 was left off or where Mr De La Poer left off, it is
2 page 12 of the internal numbering?
3 **A.** Yes, I have it.
4 **Q.** You set out here three statements, "Openness,
5 transparency and candour". Are they interlinked but
6 distinct concepts?
7 **A.** Yes, could I just start, because I haven't said so for
8 before and you represent some of them, we have been
9 talking in very general terms and I am absolutely aware,
10 if I cannot understand, the agonies that your clients
11 and others like them might be going through and I just
12 want to express my sympathies to you.
13 **Q.** Thank you.
14 **A.** But to your question, yes, they are associated and
15 interlinked and I think it would be fair to say no one
16 of them is sufficient but all of them are required.
17 **Q.** Yes. In terms of the relationship between the Trust and
18 the patient, is candour the only one of those three that
19 involves for direct interrelationship between the Trust
20 and the patient in terms of giving information?
21 **A.** No, they all are, in different ways. The thing about
22 candour, I see -- when something has gone wrong, I see
23 the relationship between the doctors and the hospital on
24 one hand and the patient and their family on the other
25 as being a continuum from the time the patient first

1 arrives and is referred for treatment through to the
2 time when they get discharged at the end.
3 At the beginning of the process, there is openness
4 and involvement in the terms of discussing with the
5 patient what their history is, what could be done, what
6 the choices are, all the stuff that goes into consent as
7 we know about it.
8 While the treatment is happening, there is
9 a continual dialogue, if we are talking about
10 a conscious patient, about the treatment, how it's
11 going, how you are feeling, and a conversation.
12 I see no reason why -- why that suddenly should stop
13 when an outcome has happened which is unexpected and
14 there is an aftermath. The -- the investigation and
15 consideration of what has happened after a treatment
16 actually is part of the care being delivered to the
17 patient and therefore the relationship should be exactly
18 the same. It should be open, it should involve frank
19 discussion and it should be transparent because you are
20 being told what's going on about your treatment.
21 **Q.** Yes.
22 **A.** And at the moment, or too often rather, once we have got
23 to that end point and things haven't gone as planned, we
24 suddenly reverse into a sort of adversarial relationship
25 which I'm afraid over the years has had a lot to do with

1 people like you and me and how people get represented in
2 litigation.
3 **Q.** If we look at in general terms healthy culture within an
4 NHS Trust, one of the features of healthy culture is
5 a dialogue between patients and doctors?
6 **A.** Yes.
7 **Q.** So we can see candour playing a part there. Other
8 features would be a healthy dialogue between staff
9 within the NHS Trust; in other words, that you don't
10 suppress --
11 **A.** Yes.
12 **Q.** -- people who raise concerns?
13 **A.** Yes.
14 **Q.** And candour, openness, transparency all play a part of
15 that as well. In your report and in a number of reports
16 there is a discussion about a culture of secrecy within
17 NHS Trusts. And again if one sees a culture of secrecy,
18 one will also see that suppressing candour as well?
19 **A.** Yes, it will. And I think that the reason some people
20 ask, I think: why did you need to have a duty of
21 candour, it was there already? And the answer
22 was: well, it was for the professionals, albeit in
23 a professional sense. But it's not that easy, it is
24 a little rather more than the doctor or the nurse being
25 frank with the patient.

1 It can be quite complicated to work out why
2 something has happened, let alone to work out how is the
3 best way to tell the patient or their family, and that's
4 the organisation's role and until Professor Kennedy
5 firstly and then just following on what he had said, put
6 it bluntly, there was no obligation on the organisation
7 to do anything about it and so needless to say they
8 didn't.
9 **Q.** But if we talk about what a healthy culture within an
10 NHS Trust looks like --
11 **A.** Yes.
12 **Q.** -- it has always involved candour?
13 **A.** Yes.
14 **Q.** A healthy Trust would always have been candid and open
15 and transparent with its patients?
16 **A.** To tell you the truth -- and I am here to tell you the
17 truth -- I am not sure that in my professional career,
18 both appearing for NHS Trusts but also for patients when
19 things have gone wrong, would I say that I have
20 uniformly come across candour on the part of the
21 organisation. That has been because despite everything
22 that the Medical Defence Union, the Medical Protection
23 Society, the NHS centrally might have said, there was
24 this thought that you can't apologise because that might
25 be an admission of liability and liability was always at

1 the forefront of the behaviours of some at least
2 NHS Trusts or their predecessors.
3 So I am not sure you are right in saying there has
4 always been organisational candour and you certainly
5 would not be -- it would not be safe to assume there's
6 you always been professional candour either but that's
7 a different issue. There's always been an obligation on
8 them and I do think that the behaviours of both
9 professionals and of Trusts has become much more open
10 and much more candid in a non-technical sense in the
11 last 10 to 20 years than it probably was before.
12 **Q.** There of course have been factors which suppressed
13 candour so the effect of litigation may suppress
14 candour?
15 **A.** Yes.
16 **Q.** A culture that priorities reputation over everything
17 else would suppress candour as well?
18 **A.** Yes.
19 **Q.** It may have been notional, but if one were to idealise
20 the perfect NHS Trust --
21 **A.** Yes, I accept that the expectation if asked would have
22 been there, yes.
23 **Q.** Yes. And the introduction of the legally enforceable
24 duty of candour that was not because it was necessary to
25 alter the concept of what a healthy culture would look

1 like, but it was to give rights to individuals who might
2 have been victims of an unhealthy culture?
3 **A.** That is correct. You say legally enforceable. There is
4 an obligation under the Regulation to be candid, it is
5 not enforceable that the -- or may not be enforceable at
6 the behest of the patient, actually.
7 **Q.** No and again when we come on to effectiveness of a duty,
8 that is one of the key points.
9 If we look at the situation in Mid Staffordshire and
10 the culture that had developed there. I can take you to
11 the report, but you may know it already very well.
12 The key features of the culture at Mid Staffordshire
13 was: a lack of openness to criticism; a lack of
14 consideration for patients; defensiveness; looking
15 inwards, not outwards; secrecy; misplaced assumptions
16 about the judgments and actions of others; and
17 acceptance of poor standards and a failure to put the
18 patient first in everything that is done?
19 **A.** Yes.
20 **Q.** Those are features that you highlighted. When you
21 reported you said that to achieve change, it did not
22 require radical reorganisation but reemphasis of what
23 was truly important. So in other words that these were
24 features of deviance from acceptable practice and there
25 needed to be a reassertion of what acceptable or good

1 practice looks like?
2 A. Well, I felt then, as I feel now, that it's very
3 tempting to look at -- do one of two things, to find the
4 person to blame is one thing and the other is to we need
5 a wholesale reorganisation to prevent this happening
6 again when neither of those steps will actually change
7 the culture. And the culture that -- sorry, the
8 structure that existed then and the structure that
9 existed now are perfectly adequate if people behave in
10 an appropriate way culturally. So you need an
11 appropriate leadership, who -- and that has to be values
12 driven at all levels and of course what you -- everyone
13 in an organisation providing health services has to do,
14 and I know this sounds trite, but it is too often
15 forgotten, is to put the patient first and that means
16 whatever you do, whether it be you are the front line
17 doctor or the accountant working out the budget, you
18 have to work out what the impact is of what you are
19 doing on the patient.
20 Q. Yes, the recommendations you were making, they weren't
21 a radical change of what people would have expected of
22 a Trust before then, once you were reasserting --
23 A. Well, a lot of what I was doing was frankly stating what
24 one might have thought was obvious but it appeared
25 not -- it appeared to have been forgotten.

1 Q. Yes.
2 A. I was -- when I delivered my report to the Government,
3 without breaking confidences I was astonished at how
4 many people at a very high level kept on telling me how
5 shocked they were to read the report and I couldn't
6 understand, and I still to some extent can't understand,
7 why they thought that, bearing in mind they had already
8 had at least one report telling them the story. The
9 reason -- the reason is, I think, that the further away
10 you get from the front line the less you think about the
11 patient and the human impact of what -- of the decisions
12 that you make and the actions that you take and you have
13 to keep that -- everyone in the health service has to
14 keep that at their mind all the time and as soon as they
15 forget that, bad things happen.
16 Q. Yes, thank you.
17 One of the features that you -- and again going back
18 to what we were saying at the start, one of the things
19 that you felt needed reemphasising was openness,
20 transparency and candour in all of the system's
21 businesses?
22 A. Yes.
23 Q. So in other words it was something that would be -- it
24 would be across the board, it would be at a level from
25 patient to doctor interaction but also in the way that

1 the board dealt with other members of the board, but
2 with the external optics of what they were doing?
3 A. Yes, it's throughout. I mean, how the different levels
4 you have described act in order to do that of course
5 will be different but it should be second or first
6 nature for the doctor, the nurse, to be being frank with
7 the patient about problems, if there are problems,
8 affecting them.
9 Likewise it should be first nature for the board to
10 be open about things that are not going well, both
11 internally and where appropriate externally in order to
12 effect improvements from their patients and not all
13 things that have gone wrong are in the control of the
14 board or the individual but they need to be open and
15 honest about them and any attempt to shut that down in
16 my view prejudices patient safety.
17 Q. Yes. Because candour, openness, transparency, it is
18 interweaved with patient safety along with a number of
19 other issues?
20 A. Yes.
21 Q. As I asked you at the outset, if you can trace the
22 connection between candour and other issues within
23 a failing Trust quite easily, it will be one of the
24 symptoms, a failure to be candid and open?
25 A. One of the first ways I knew there was a definite

1 cultural issue at Mid Staffordshire was during my first
2 Inquiry which happily not being a Statutory Inquiry
3 meant I could go anywhere I wanted to and talk to anyone
4 I wanted to without an array of people taking down what
5 was said. And I bumped into a nurse in the corridor and
6 I asked her how things were going and she looked --
7 I know very scared, but I said "well, tell me about your
8 ward" and she told me a story about how she had made an
9 improvement on her ward, it was a nice little story, it
10 was perfectly encouraging and so on. But she looked
11 around her and she said "I can't believe I am telling
12 you this" and I thought that if someone was scared to
13 tell me about something that was good, what on earth was
14 their mindset going to be about something that wasn't?
15 There was a consultant who would only see me at his
16 home in secret to tell me about a matter of concern,
17 a matter that concerned him. He wouldn't even put it in
18 writing, he wouldn't come to -- as it happened, he
19 probably wouldn't want you to know this now, but it was
20 something I knew about already, but that was the level
21 of fear, a senior consultant, long since retired now,
22 felt he could not be open about something.
23 So that's the level -- and this is not uncommon, the
24 experience around NHS Trusts in this country, still to
25 this day.

1 Q. You spoke about the airline industry and of course there
2 is a culture within the airline industry that if there
3 is a problem, even if it was caused by the pilot
4 activating the wrong button, they should be open and
5 talk about it because it allows people to engineer
6 solutions to that problem. So you encourage an
7 environment where people can talk about their own
8 mistakes --
9 A. Yes.
10 Q. -- without consequence.
11 A. Yes. People often -- one of the unfortunate
12 characteristics of health service people, if I can be
13 general, is that there tends to be a response saying:
14 that's the aviation industry, that's the nuclear
15 industry, we are different. To which my answer
16 is: well, of course you are different, but you are both
17 in the business of keeping people safe.
18 Q. Yes.
19 A. And the thing about pilot issues or the airline industry
20 is not -- we often talk about the pilots, and of course
21 they have their particular thing. But it's true of the
22 engineers and the maintenance depot: a mechanic who
23 drops a wingnut and can't find it will go and tell
24 someone "I have dropped the wingnut, I can't find it",
25 because he knows that's a potential safety issue and

1 although he has made a mistake, he needs to do something
2 about it straight away.
3 That's what they do and it is second nature to them.
4 Q. Yes.
5 A. I mean, there will be of course exceptions to that work,
6 but that's their culture.
7 Q. If we go back to your statement and it is internal
8 page 19, it is page 20 of the pdf document that I have.
9 A. Yes.
10 Q. You were asked about the differences in -- forgive me
11 a moment, sorry. Sorry, it is page 38.
12 A. Is that internal 38?
13 Q. It's entitled "Healthy culture"?
14 A. Yes.
15 Q. So you were asked to define a healthy culture in the NHS
16 and specifically in any NHS neonatal unit?
17 A. Yes.
18 Q. How would you define a healthy culture in 2005 and the
19 years that immediately followed that with regard to
20 candour in an NHS Trust or NHS neonatal unit?
21 A. Well, I think -- I mean, it is very difficult coming up
22 with exhaustive definitions but in 2015, I would have
23 expected a general understanding and acceptance and
24 implementation of candour, the duty of candour as
25 contained in what would have been the regulation by

1 then. But even without the regulation, without wishing
2 to both boast about one's own report, the impact of that
3 report or reports was sufficiently widespread that no
4 one anywhere in the NHS was likely then to have not
5 understood the importance of doing it.
6 So I think the duty of candour would have -- should
7 have been pretty embedded by then. I wouldn't
8 necessarily be confident that any -- that the actual
9 process would, but the need for it.
10 In terms of Freedom to Speak Up, my report would
11 have just come out and I would have expected leaders at
12 least to be aware of the principles. It would be fair
13 to say that by no means all, in fact probably only
14 a minority of organisations at that time would have got
15 around to having a Freedom to Speak Up Guardian. That
16 took quite a long time to happen for reasons.
17 Q. I should say Mr Skelton is dealing with --
18 A. Okay I will leave that. You did ask what I thought
19 about the -- but it is part of a healthy culture that
20 there should be a feeling of lack of fear and I am not
21 sure whether I could say that at that point that much
22 had happened to change that, to be honest.
23 Q. I mean, the concept of candour had existed, the idea you
24 should be candid with patients had existed prior to
25 2015?

1 A. Oh, yes.
2 Q. And I think failures in patient safety and the
3 interrelationship between candour and poor safety
4 culture of NHS Trusts was also well known about by the
5 time we get to 2015?
6 A. Yes.
7 Q. It had been a feature of your report, it had been
8 a feature of other reports as well.
9 A. Yes, I think that I am not sure whether by then there
10 was necessarily the full acceptance that there would be
11 today of taking the risk, if you like, of fuelling
12 litigation which is a mistaken fear, but I think was
13 pretty strong at the beginning of this century and by
14 2015 I don't think it would have necessarily dissipated.
15 The MDU, the MPS and the NHS Litigation Authority were
16 still having to keep on reminding people that apologies
17 were not an admission of liability and all that and
18 I think that there was still a lot of professional fear
19 of telling the truth, the whole truth and nothing but
20 the truth about things.
21 Q. At the organisational level by the time we get into
22 2015, we do have a statutory duty of candour being
23 introduced --
24 A. We do.
25 Q. -- Which changes things significantly?

1 **A.** Yes.
2 **Q.** I think you say in your statement that it is
3 inconceivable that any NHS manager would have been
4 unaware of the duty of candour by 2015?
5 **A.** Well, nothing is impossible, is it? But there is no
6 reasonable excuse for anyone who had been in post in the
7 NHS for more than -- less than a few months would not
8 have known about it.
9 **Q.** So unless they had literally just popped into the job
10 with no prior warning, they should really have been
11 aware of the duty of candour in 2015?
12 **A.** Yes.
13 **Q.** Certainly in terms of individual duties, I mean, there
14 had been a professional duty upon doctors and nurses
15 prior to 2015 to be candid where things went wrong or --
16 **A.** Yes. Interesting there has always been -- but
17 interestingly, not that I have done a survey on it, but
18 I am not aware of a significant number of cases ever
19 being taken by the GMC about candour. Lots of things
20 about consent and relationships with patients and so on
21 but just that little bit of it I am not sure produced
22 much by way of enforcement at the time.
23 **Q.** No. What do you say in relation to candour and neonatal
24 units specifically? Do you think the duty of candour
25 would have been felt or should have been felt to apply

1 to a neonatal unit in the same way or should it have
2 been more enhanced in that context?
3 **A.** Well, I think it is the same duty. I mean, obviously
4 the qualification is that you are being candid to
5 parents or people with parental responsibility rather
6 than the patient directly. But that's true across
7 children, people who can't make decisions for themselves
8 generally. I -- but the duty is as much there.
9 I think the relationship with -- between the medical
10 profession and parents is a slightly more complicated
11 one than directly with the patient because interspersed
12 there is the need for a judgment about the best
13 interests of the child and not -- not always do the
14 interests of the child coincide entirely with the
15 interests of the parents. So there can be issues there
16 about how you say things, when you say it, I think in
17 a way which are more complicated.
18 But that's about children in general. I would say
19 that the duty of candour -- there is no difference in
20 the quality of the candour required in a neonatal unit.
21 Sensitivity is required, compassion is required of
22 a very high order indeed, but that's not the only place
23 in the hospital where those things are required.
24 **Q.** I think in your report at 3.5.1 you say:
25 "Clearly the duty of candour as formulated in the

1 regulations applies as much to neonatal units and care
2 as any other treatment of care. Also clearly the
3 patients are particularly vulnerable: they cannot speak
4 for themselves, their mothers may be suffering from
5 postnatal issues which reduce their ability to represent
6 their baby's interests in the immediate aftermath of
7 a birth, and parents and families will in any event be
8 experiencing considerably emotional stress. Therefore
9 the context in which all the values and duty considered
10 in this report have to be complied with is particularly
11 demanding."
12 **A.** I think that's what I meant by what I have just said
13 that on any view there can be a little more of
14 a nightmare facing any parents than having their child
15 seriously ill in a neonatal unit, particularly
16 a neonatal Intensive Care Unit. I have visited in the
17 course of my career places like that and the atmosphere
18 to them is entirely different to anywhere in the
19 hospital I have ever been, but the care and compassion
20 and the demands that brings on the staff are tremendous
21 and also there is something about the speed at which
22 things happen or have to be done.
23 This is not me being an expert pediatrician, but
24 just observing it, the need to manage the exchange of
25 information with very distressed people who may not be

1 able immediately to take in what you have said happens
2 in many places in medicine, but I imagine are
3 particularly acute in the setting of an Intensive Care
4 Unit.
5 So I would say that the skills required are of
6 a higher degree in a place like the neonatal unit than
7 perhaps they are elsewhere.
8 **Q.** Yes.
9 **A.** We don't, I think, often pay -- give enough thought to
10 the impact that those stresses have on the staff who
11 work there and the need to provide them with support and
12 advice to be able to do these very difficult tasks. And
13 one of the reasons for having the organisational duty is
14 to in effect meet -- to require the employer, the
15 provider, the organisation, to give their staff the
16 necessary support to do this job properly, because it's
17 when you get around to candour in the sense that harm
18 has been done to someone's child and you are having to
19 explain that to the family, let alone when they have
20 died, is of a particularly demanding nature and not many
21 of us left to our own devices could do it well. We need
22 help.
23 **Q.** Yes and challenges of course to the dialogue and the
24 circumstances in which the dialogue takes place?
25 **A.** Yes.

1 **Q.** But of course you still have to be honest and not
2 mislead?
3 **A.** Yes.
4 **Q.** Parents of children, especially very vulnerable children
5 and very vulnerable parents, it is important to be
6 honest with them?
7 **A.** One of the things you have to be honest about is what
8 you don't know.
9 **Q.** Yes.
10 **A.** There's I think sometimes a feeling that candour is
11 about producing a finished conclusion and result. It's
12 not. It's about telling people that something may have
13 happened. I mean, that's why the regulation talks about
14 "may have been harmed". It is not just about actual
15 harm.
16 **Q.** What role does leadership from the board and the
17 Chief Executive play in relation to a duty of candour,
18 how important is good leadership?
19 **A.** Well, it is absolutely essential in a number of ways.
20 First I think as I have indicated if everyone in the
21 organisation can see that Chief Executive or their
22 leader is not being candid themselves about something
23 everyone knows about internally, then they get a message
24 about that. Equally, it is essential that the leaders
25 produce the environment in which facilitates being

1 candid as opposed to insidious activities which may do
2 the opposite. It is not difficult to discourage people
3 from being honest, being open about things that have
4 gone wrong and quite often in a human way sometimes it
5 is much easier to do that. So it is important that
6 leaders support and encourage people to do the right
7 thing, even though that's very difficult.
8 **Q.** And it starts with the example that they set?
9 **A.** It starts with the example they set and that can
10 permeate down through the organisation too. And I mean
11 the really difficult cases come where there is
12 disagreement. It's not always -- there are a lot of
13 things we talk about candour, it's assumed that we all
14 agree something has gone wrong and why it has gone
15 wrong. Often we know something has gone wrong but we
16 don't know why and sometimes there will be different
17 opinions about what has happened, let alone why it
18 happened, and that's why it is very necessary in
19 exercising the duty of candour to have a proper,
20 objective and fair investigation process which is so
21 often missing and so that must be particularly important
22 and difficult in the circumstances of a neonatal unit.
23 **Q.** Of course candour doesn't begin with reaching the
24 conclusion that something has definitely gone wrong. It
25 begins with the investigation and keeping patients aware

1 of the fact that there is investigation?
2 **A.** Yes, yes.
3 **Q.** Finally, it's -- I want to take you to a letter that
4 appeared in The Times over the course of the weekend.
5 **A.** Yes.
6 **Q.** It is at INQ0108030.
7 **A.** Yes, I did see it, but I would be grateful to see it
8 again if you want to ask me about it.
9 **Q.** It relates to an announcement of the Hillsborough Law
10 which may or may mirror the NHS duty of candour and it's
11 a letter from Bill Kirkup and Bishop James Jones, both
12 of whom you refer to in your statement, reporting on the
13 introduction of the Hillsborough Law, you say that:
14 "A statutory duty of candour already applies to NHS
15 providers and that the new law would widen this duty to
16 include all public servants and bodies. There are
17 significant problems with this. The NHS duty of candour
18 is implemented at best as a one-off disclosure with no
19 requirement for honesty and openness thereafter. The
20 subsequent change of stance by staff, often evident in
21 investigations, complaints, inquests and litigation is
22 deeply distressing certainly to the families at the
23 heart of these maternity services investigation and
24 others. This would be a poor model.
25 "If we suppose that the NHS already has this right

1 we will miss a major opportunity to reform the NHS duty
2 of candour. A statutory and enduring duty of candour
3 for the NHS is called for and the report of East Kent
4 maternity services investigation would mean significant
5 improvement in response to families harmed and bereaved
6 by patient safety incidents."
7 Would you have any comments in relation to that?
8 **A.** I would. Both Bishop Jones and Bill Kirkup deserve
9 a huge amount of respect for what they have done and
10 contributed to the understanding of safety in this
11 field, but I don't understand the NHS duty of candour as
12 being a matter of a one-off disclosure. I have
13 described it I think more as a process and if it is
14 being treated as a matter of one-off disclosure, then
15 I believe it is being treated wrongly.
16 **Q.** Yes.
17 **A.** And I would -- my interpretation of the regulation is
18 that candour starts with telling the patient or the
19 family something has or might have gone wrong and we are
20 going to investigate it and it carries on until such
21 time as there is a conclusion, often this will be at
22 a meeting at which the results of the investigation are
23 shared, and there is at that point -- maybe there has
24 been already -- but a renewed apology, an explanation
25 and a statement as to what's been done about to learn

1 lessons.
2 If you call that one-off disclosure, well it's
3 actually a process and I think to say that there is no
4 requirement for honesty and openness after that is also,
5 with respect, wrong because clause 1 of the regulation
6 talks about the need for, overarching need for openness
7 and transparency so that never goes away. Candour, in
8 the technical sense, might because you have done
9 whatever you can do about the incident and the harm and
10 you then, as it were, move on from that particular
11 incident.
12 But I don't -- I wouldn't -- I think it's unfair to
13 call that a one-off disclosure.
14 **Q.** I think the duty as drafted is not a one-off disclosure.
15 I think what's being said here and obviously Dr Kirkup's
16 experience of East Kent is that that's how it's treated
17 people; that have a tick box exercise at the start, they
18 do the candour and then they don't follow that
19 obligation through.
20 **A.** Yes, well, he does say that and that may be the case.
21 But I don't think that's the duty. That's the way it's
22 being dealt with at East Kent as he found and maybe some
23 other places.
24 So I think it would be fair to say that the duty of
25 candour as currently defined is not being properly

1 implemented in a lot of places and I think it would be
2 wrong to say that the duty of candour as defined is --
3 would not -- is not appropriate in the NHS.
4 Whether it's appropriate in that form to spread more
5 widely I think is a question for others.
6 **Q.** Yes. So the duty as drafted requires ongoing honesty
7 and candour with patients?
8 **A.** Yes. Well, the -- the whole relationship, therapeutic
9 relationship with a patient and their family is
10 predicated on it being open and honest and, you know,
11 with all that implies. The technical candour is about
12 what happens to investigate a particular incident of
13 harm and rather like an incident treatment there comes
14 a point where everything has been done that could be
15 done about it, but that doesn't mean that there is
16 anything wrong with the duty underlying that.
17 **Q.** Would you change anything about the duty of candour as
18 it stands at the moment?
19 **A.** Well, I would certainly change the way it's dealt with.
20 I think it will be right to say, as I think I have
21 already said, that it is treated too much as
22 a bureaucratic process and a defence mechanism rather
23 than an opportunity to involve the patient or the family
24 in a process of investigation and learning to go
25 forward.

1 I think it's often forgotten, too often anyway, that
2 patients and their families are experts. They don't
3 know about medicine but they are experts in the way in
4 which they have been treated and that's often at the
5 root of what has gone wrong and needs to be put right.
6 So an investigation that doesn't involve them and take
7 them along and produce preferably a consensual useful
8 result has failed. And you don't do that just by asking
9 people to fill in forms and sending them letters; you do
10 it through human interaction and discussion.
11 It takes time and it takes resource but if you don't
12 do that, you haven't done the job properly.
13 **MR BAKER:** I am grateful. Thank you, Sir Robert, thank you,
14 my Lady.
15 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,
16 Mr Baker. Mr Skelton.
17 **Questioned by MR SKELTON**
18 **MR SKELTON:** Sir Robert, I ask questions on behalf of one of
19 the other Family Groups.
20 I have got 30 minutes to ask you about speaking up.
21 I appreciate it has been a long day.
22 **A.** Right.
23 **Q.** So I will try and keep it focused.
24 Can I just give you an outline of the topics I would
25 like to cover if I may. First of all, the review that

1 you took in 2015; secondly, your view on the present
2 state of play including the implementation of your
3 review and its effects; a couple of specific issues
4 about support for those speaking up and the guardians
5 and response to those concerns when people do speak up
6 which are clearly the sort of starting point and the end
7 point of that process and then try and draw together
8 your views on what now needs to change, but with a very
9 specific, if I may, on transgressive behaviour and
10 concerns about that behaviour for obvious reasons that
11 resonate in this Inquiry.
12 Can I start then with your review in 2015.
13 Could you summarise for the benefit of my Lady the
14 principal problems that you diagnosed in 2015 when you
15 undertook your review?
16 **A.** Well, I think it started with the reason the review was
17 set up was that there were case histories, if you like,
18 or cases of about 20 healthcare staff who one way or the
19 other having raised concerns of a wide variety of things
20 but some were patient safely, most were about patient
21 safety, but some were about fraud or other issues, and
22 all of these people having raised the concern had found
23 themselves the subject of an investigation or adverse
24 action of some shape or form.
25 Some had lost their jobs, many had been subjected to

1 behaviours which had resulted in serious compromise of
2 their mental health and none of them felt that they had
3 received any sufficient remedy or justice for that. So
4 that's why the review was set up.
5 My job however was not to investigate the merits of
6 their individual cases or to deliver justice, much to
7 their distress I should say, but to review the treatment
8 generally and what I found was -- not everywhere of
9 course -- but insofar as one could tell there was far
10 too many cases where doctors, nurses and others had
11 raised issues of concern and had been immediately met
12 with what I will call a personalisation of the issue.
13 So instead of someone looking into an issue, finding
14 out what the truth of it was and then finding a remedy
15 for it, it would be turned into a suggestion very
16 quickly that fault was not in relation to the concern
17 but the person raising it was doing this for an ulterior
18 motive, sometimes allegedly to cover up their own
19 incompetence, sometimes because of a personal vendetta
20 against somebody else. So the whole thing would become
21 an issue about looking at the person and their character
22 and their ability rather than looking at the issue that
23 they had raised.
24 And this seemed to permeate quite a lot.
25 I discovered that certainly that the remedies available

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1 by way of employment law didn't seem to protect anybody.
2 The -- where this had happened there was no system
3 providing support for people who had raised concerns at
4 that worked.
5 Often frankly their Union representative would be
6 conflicted because if the concern was about another
7 colleague then often they would be represented by the
8 same, members of the same organisation basically -- and
9 the effects on people's behaviour, this when all this
10 happened to an individual put to these sort of
11 detriments, they became desperate people and that
12 sometimes led them to behaving in a way they would
13 probably later regret. So they would often end up be
14 provoked into providing their employer with an excuse to
15 get rid of them, if I can put it bluntly, and this is
16 desperate.
17 Quite often it would subsequently transpire that
18 what the individual had complained about was correct,
19 some time later, some bigger disaster would happen and
20 eventually they would be vindicated. But that would be
21 no comfort to them because they would be without a job,
22 no one was going to offer them another job and so on.
23 So by no means was this something that happened
24 everywhere or all the time. But the other thing was
25 that you don't need many such cases, in fact you only

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1 need one or two such cases to send a message out to
2 everybody else: it's not worth the candle raising my
3 head above the parapet because I will become persecuted
4 and I won't solve the problem because no one will listen
5 to what I would say.
6 Then if you looked at it, it was -- we have got more
7 information now than we had at the time, but staff
8 surveys and so on would suggest that a significant
9 proportion of staff at the NHS would not -- did not have
10 confidence that if they raised issues that someone would
11 deal with them, so there was: what was the point
12 therefore of doing it?
13 So that was the sort of picture I was presented
14 with.
15 **Q.** You have been involved with the Bristol Royal Infirmary?
16 **A.** Yes.
17 **Q.** And you mentioned that inquiry earlier and the paradigm
18 example it that inquiry was the consultant anaesthetist
19 --
20 **A.** Yes.
21 **Q.** Dr Steven Bolton, who raised concerns about higher than
22 normal, as he perceived it, cardiac mortality in infants
23 that were being treated there.
24 **A.** Yes, exactly.
25 **Q.** But eventually lost his job and in fact left the

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1 United Kingdom and went --
2 **A.** He's been in Australia ever since, yes.
3 **Q.** And that was 1999, 1998/1999.
4 **A.** Yes.
5 **Q.** So given that, did that in fact have the opposite effect
6 it should have done? Rather than bringing to the fore
7 the value of whistleblowers it had in fact publicised
8 the demonisation of a whistleblower?
9 **A.** Well, I suspect it did have an effect like that, but
10 I don't think his was the only case.
11 But his was a typical case, if you like. The
12 isolation, to isolate someone as being different and
13 a maverick and therefore you didn't have to look at his
14 figures because he had -- he put together the figures
15 that showed that there was a problem with this
16 department.
17 And in the end, he had in order to get attention to
18 them, he literally handed them over in a brown envelope
19 in the back of a taxi to someone from the Department of
20 Health and, you know, when you have to -- he
21 subsequently found no one wanted to talk to him and he
22 did leave the Trust and he never got another job in this
23 country, so -- and he is not alone. There are a number
24 of people who have suffered similar fates and are to
25 this day concerned. The -- and many of them will have

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1 been to and failed in tribunal cases which is perhaps
2 another issue to be dealt with.
3 But, anyway, so that was what I had to confront. So
4 I thought, again, you can have rules and regulations
5 about fair treatment of people but again, I'm afraid,
6 this is cultural and you need a system which welcomes
7 people raising concerns and you need to have principles
8 of good practice and I thought I was more likely to get
9 somewhere if I set out some principles with one or two
10 supports for that than trying to rewrite the law of
11 discrimination.
12 Q. You did identify I think 12 -- sorry, 20 principles?
13 A. 20 principles.
14 Q. And associated actions.
15 A. Yes.
16 Q. I won't go through all of them.
17 A. No.
18 Q. In the interests of time --
19 A. You could tell which page I put them down on.
20 Q. I was looking at your original document. You do mention
21 them in your first report at page 99, I think.
22 A. Thank you.
23 Q. At least in the overarching points.
24 But they include recommendations on improving the
25 culture of safety, raising concerns, freedom from

1 bullying and visible leadership I think all of which you
2 have touched on today?
3 A. Yes.
4 Q. They also provided some specific measures for the
5 investigation of concerns and of course the introduction
6 of the guardians?
7 A. Yes.
8 Q. So that was 2015.
9 A. Yes.
10 Q. For the purpose of this Inquiry, I think you have
11 revisited the present state of play. Is your diagnosis
12 essentially the same with some improvement?
13 A. Well, let me -- I think that the system of guardians is
14 now I think 100% in place in that everyone has
15 a guardian. Most organisations have in addition what
16 one might call assistant guardians; they call them
17 ambassadors or champions or whatever. So there is
18 a system of people to whom members of staff can safely
19 go to share a concern, get support and advice about what
20 to do about it.
21 That is working better in some places than others
22 because not everywhere is supporting their guardians
23 properly by giving them time to do the job, sufficient
24 time or sufficient resource. It's demanding and
25 stressful work, for reasons everyone will understand,

1 and in some places slightly surprising appointments are
2 made of people who clearly, in my view, have a conflict
3 of interest. So it would not occur to me if I were
4 Chief Executive of a Trust to appoint someone who was
5 either the HR director or in the HR department to do
6 this work, still less a non-executive member of the
7 board. There is a place for someone to be interested in
8 the subject of a board but not to be the guardian.
9 So, there -- but it took a long time to get there
10 and so not everywhere had a guardian at all for quite
11 some time. So, but I think that is -- we are now pretty
12 well there.
13 And the advantage of that which we didn't have at
14 the time, because we also of course have the
15 National Guardian, is that figures are being collected
16 about not only the numbers of cases they are dealing
17 with, where they are dealing with them but information
18 is coming in about places that are doing it well and
19 places that are not doing it so well.
20 So I think it has changed. But there are still
21 examples of, in my view, egregious behaviour towards
22 whistleblowers which is often seen funnily enough --
23 well, not funny at all -- not so much in the raising of
24 the concern end of it but where something has gone wrong
25 often years ago and a place has gone to a tribunal you

1 see the Trust defending the indefensible at a tribunal
2 and then excoriating judgments being made about the
3 behaviour not of the Chief Executive or whoever were in
4 place at the time but the leadership today, at the time
5 of the tribunal hearing, and then after that there is
6 a decision and nothing follows from that because: well,
7 that was a tribunal case, it's not fair to do anything
8 because whoever the executive director was wasn't
9 a party to the case, the decision is not binding on them
10 and so on.
11 So I think there is work to do about the behaviour
12 of leadership generally in the way that it treats the
13 past whistleblower cases as well as the current ones.
14 Q. So you report a number of sort of instances in the media
15 of victimisation of whistleblowers --
16 A. Yes.
17 Q. -- which almost appear to be the same of those that
18 would have occurred in Bristol and --
19 A. Yes.
20 Q. -- formed the basis for your review?
21 A. Yes.
22 Q. That's still going on?
23 A. That still is. Obviously when one is looking at
24 individual reports and individual cases, it is very
25 difficult to untangle the merit and it would be wrong

1 for me to make judgments. But where you get an
2 employment tribunal who has looked into it, heard
3 evidence and the Trust has been able to bring forward
4 whatever evidence it wants to, and given the hurdles
5 that a whistleblower has to overcome to get a remedy
6 which are highly technical tests then it seems to me you
7 have a strong basis for feeling that something bad has
8 happened.
9 **Q.** As far as you are concerned, is the problem to some
10 extent implementation of the healthy culture and good
11 practices that you have identified since there is no
12 absence of wisdom?
13 **A.** No, well, again, it's one of the things that a CQC when
14 inspecting a hospital is meant to and does, will look at
15 and also the National Guardian can undertake case
16 reviews. It only has the resource frankly to do rather
17 fewer of them than I suspect she would like to do. So
18 there is a regulatory power at least to take action
19 where the Freedom to Speak Up principles are not being
20 applied.
21 But like all forms of sporadic regulation, if you
22 like, which involves inspection or report, the
23 inspectors are not there all the time and these things
24 perhaps they -- unless you have got culture in place the
25 wrong thing can easily happen.

1 **Q.** This is sort of culture by a deterrent effect of knowing
2 that if you don't act appropriately the regulator is
3 going to identify you as --
4 **A.** Yes.
5 **Q.** -- as not doing so?
6 **A.** And -- but my -- the way I saw it at the time, and
7 I think I have been proved wrong, was that the Fit and
8 Proper Person regulation would be capable of being used
9 to weed out of the system leaders who were oppressive
10 towards people who raised concerns and I don't think
11 that has happened. And the person to ask about that is
12 Mr Tom Carver KC who has done a review on this very
13 subject and all I will say about his report is that
14 I agree with what he says.
15 **Q.** So by analogy with the duty of candour, is it the case
16 that you would like to see the regulators being more
17 engaged with this issue and actually taking direct
18 action so as to send a message nationally?
19 **A.** Yes, well, I think it could -- I agree, I think a
20 regulator could. But also insofar as we do have
21 a top-down system and NHS Trusts are licensed by
22 NHS England through its regulatory powers because it has
23 taken over the power Monitor used to have, I mean it's
24 one thing as I said we seem to see Chief Executives
25 leaving the door when the CQC has made a negative

1 report. The NHS England has a role to play, it seems to
2 me, in ensuring that the right culture in this area is
3 put into place and one of the things I recommended they
4 do at NHS England, and to be fair they did it for
5 a time, was that they should in themselves have
6 a support mechanism for whistleblowers who have been
7 victimised, particularly those who have lost their jobs,
8 and for a time they sought to help people find jobs who
9 fulfilled a certain definition.
10 They have now changed that, so what they are doing
11 is -- they are not doing that but they are providing
12 sort of psychological support and counselling to people
13 who have suffered in this way. I am not saying that's
14 a bad thing, but I don't know whether it is sufficient
15 and I have not looked into it sufficiently to know, but
16 I suspect it's not. And there is, it seems to me,
17 a moral duty on the part of the National Health Service
18 to do what it can to support people who have suffered in
19 this way because they have done the right thing.
20 **Q.** You mentioned the need to have the appropriate people
21 being guardians and you gave --
22 **A.** Yes.
23 **Q.** -- an example of the Chief Executive or the
24 human resources director perhaps not being the right
25 kind of person.

1 In a hospital or Trust, where almost everyone is
2 either employed by the Trust or engaged somewhere by
3 them as a non-executive director for example, how can
4 you have such a person?
5 **A.** Well, I notice that Professor Dixon-Woods suggested
6 there should be some externalisation of guardians.
7 **Q.** Yes.
8 **A.** I am not against the idea of there being some form of
9 external support or overview, but the whole purpose of
10 the guardian actually is that they are inside the
11 organisation because they need to be -- firstly, they
12 need to be people who are known or can get to be known
13 by the staff and the executive and they need to be
14 exceptional people in that they need to have the
15 confidence of Trust, as it were, of both the staff and
16 the people who lead the organisation and they need to be
17 given the freedom to access anyone, open any door they
18 want to and go and see people and informally suggest
19 that something needs to change or be done and you -- to
20 have someone external doing that, I don't think it
21 necessarily works.
22 The point about it is you can rightly say it's
23 a challenge to be working in that organisation, doing
24 things that are uncomfortable but that frankly is the
25 whole point of it and if -- the healthy culture is one

1 which encourages a level of awkwardness and challenge to
2 what is going on in order to improve it, so it is an
3 improvement culture.
4 So you need to have people who are diplomats
5 certainly because, you know, you could do this the
6 right -- you can do this in a way which gets everyone's
7 back up and nothing ever changes, but you can get people
8 who are very good at being facilitators. And the NHS is
9 full of caring people -- you often forget that -- very
10 caring and compassionate people, but who are also very
11 determined and can analyse things.
12 So you need that sort of person doing the job but it
13 can't be a director and it can't be someone who works in
14 the HR department. But it can -- they range, the ones
15 I have met, from people who work in quite apparently
16 lowly positions but develop a natural authority to
17 people who are middle-grade managers or doctors or
18 nurses or whatever. They are often nurses who manage to
19 do this job.
20 **Q.** Is there a scope for having someone who does this as
21 their job full time?
22 **A.** Definitely, yes, in some cases it is.
23 **Q.** Because certainly what one sees in this instance is that
24 the people who you are going to go and see have clearly
25 got a conflict of issue *(sic)*. If you are raising

1 a concern which could bring down all sorts of
2 consequences upon the Trust. If you do act on it those
3 consequences will happen, if you don't act on them they
4 won't and you are clearly in a conflict situation there
5 if you are employed by the Trust at a senior level.
6 But having someone independent within the Trust full
7 time whose job is to bring those concerns to the board,
8 to whoever needs to act on them, might be one potential
9 solution?
10 **A.** I -- I think that organisationally that potentially
11 becomes quite difficult and frankly if -- if you need
12 that, if you actually need that because you can't have
13 someone internally then I think you have already got
14 a culture that you shouldn't have.
15 So I see guardians as being, you know, I hate to say
16 this because it's a bit trite, but they're the sort
17 canary in the mine. They are a first signal if the
18 guardian is beginning to get into trouble for what they
19 are being asked to deal with, that in itself is a heavy
20 warning sign and they have a remedy.
21 They can externalise things in two ways: they can
22 get help from the National Guardian, they can report
23 matters themselves to the CQC or indeed NHS England. So
24 they have an ability to get help and they have
25 a network. One of the great things about guardians is

1 that they meet, the National Guardian sets this up.
2 They have reachable meetings, so there is a network of
3 guardians from -- so they can tell their story
4 confidentially or get help and advice from people who
5 don't work at their hospital. So they are not entirely
6 isolated in the way that the individual whistleblower
7 is.
8 I am not saying it will sort out all problems, but
9 I would not like to see the guardian, the Freedom to
10 Speak Up Guardian being something that is externalised.
11 The way that works is in itself a strong signal as to
12 whether the organisation is doing the right thing by way
13 of Freedom to Speak Up. In a way, it would be able to
14 say: this isn't my business, it's the business of this
15 external independent person and, by the way, who is
16 going to employ that person? You know, where do they --
17 what's the career in that? There are all sorts of
18 issues that I would think, with respect, would be quite
19 difficult to solve.
20 **Q.** So trying to see in practice how the guardian might work
21 when they are receiving a concern about transgressive
22 conduct, they are not just signposting the person in the
23 right direction.
24 **A.** No.
25 **Q.** They have a more active or proactive role in certain

1 situations. What would you see as the appropriate
2 response to a concern at that level raised by a member
3 of staff?
4 **A.** About transgression?
5 **Q.** About transgression, yes?
6 **A.** "I think someone may have killed somebody."
7 **Q.** Sorry?
8 **A.** I think -- the concern being that you fear that someone
9 is murdering a patient.
10 **Q.** Well, that's the paradigm example, yes.
11 **A.** Well, firstly we might be assisted if we had the sort of
12 checklist that we were talking about earlier; a protocol
13 as to what to do when they raise concerns and the
14 guardian would absolutely be someone who would be
15 expected to know about that and be able to give advice
16 from it as to where -- I mean a lot of this can be
17 gatekeeping.
18 You would have thought, wouldn't you, that
19 a guardian in those circumstances might advise the
20 individual to go to the police. You would be -- expect
21 the guardian to be offering fairly regular support to
22 the individual to make sure that they weren't, you know,
23 being victimised or whatever and you would be reassuring
24 that person that they don't have to prove their
25 suspicion; they just need to raise it in the right

1 quarters wherever that might be.
2 If they have tried to raise it internally and they
3 got nowhere, then you have to start advising them about
4 the external places you can go to and we have listed
5 them. It's the police, it's the Care Quality
6 Commission. They may need support from a Union, but
7 there are all sorts of things that can be done.
8 And the guardian also has a role, as you say it's
9 not just a signposting exercise, the guardian's role is
10 to open the door of whoever is necessary, one might have
11 thought in this case the Chief Executive and
12 say: a serious concern has been raised here, what is
13 happening about it?
14 If they are told to get lost, putting it bluntly --
15 and I am not commenting on this case at all, I have no
16 idea what happened at the Countess of Chester -- but if
17 they are told to get lost that's a point at which you
18 would like to think they would externalise it by going
19 to one of the people or organisations we have mentioned.
20 But the big thing about it would be that the person
21 who has raised this concern has got the concern, he is
22 no longer alone, they are not on their own. They have
23 got someone who will help them if that victimisation
24 process starts.
25 **Q.** Going back to a point I think you made earlier, which is

1 the person who is receiving it, whether it's the
2 guardian or the person who the guardian then has to
3 speak to initiate the investigation, the priority has to
4 be thinking about the patients?
5 **A.** Yes.
6 **Q.** That has to be the touchstone for the appropriateness of
7 the response?
8 **A.** Yes.
9 **Q.** So if an issue of transgressive behaviour is occurring,
10 you have the existing patients who may have been harmed
11 and you have the future patients who may be harmed if
12 something is not done?
13 **A.** Yes. So the -- in an extreme, and we are talking about
14 a very extreme case, but that's what this Inquiry
15 appears to be about, then the responsibility taken on
16 the guardian's shoulders is also extreme and I can quite
17 imagine that a guardian might want to have external
18 advice pretty quickly on that and would get it,
19 I believe, from the National Guardian and they have
20 a direct line of contact. There are not so many of them
21 that the National Guardian doesn't know most of them
22 personally.
23 **Q.** Where might the roadblocks then occur? So if the
24 guardian is responsive the guardian maybe takes external
25 advice because the issue is too big for them to

1 necessarily find the appropriate response outside of
2 their usual zone of concern?
3 **A.** Yes.
4 **Q.** But when they attempt to trigger investigation
5 internally the response isn't the appropriate one, the
6 management aren't acting in the way you described the
7 Florence Nightingale approach of understanding what they
8 need to do in response to protect patient safety. What
9 then happens or what should happen?
10 **A.** Well, I believe that the -- a port of call, not
11 necessarily the only one, would be the Care Quality
12 Commission and you can point to the obligations of the
13 Trust in terms of leadership in the face of a serious
14 risk of an allegation and something which potentially is
15 compromising the safety of patients, the Care Quality
16 Commission is there to deal with it.
17 Now, what they would do you would have to ask them
18 but I think that to my mind would be one the reasons we
19 have a regulator.
20 **Q.** Do you think the guardian sufficiently understand the
21 intersection between their own role and that of
22 safeguarding for example? You obviously have talked
23 about that in your report.
24 **A.** Yes.
25 **Q.** But to some extent, some of these policies sometimes

1 exist in their own ecosystem --
2 **A.** Yes.
3 **Q.** -- and there is another set of policies and procedures
4 which you have heard about from Dr Garstang which is the
5 investigation of children's deaths?
6 **A.** Yes.
7 **Q.** So you have a safeguarding system, you have an
8 investigation of children's death and mortality system,
9 you have a whistleblowing or speaking up system.
10 Are they joined up sufficiently in your view?
11 **A.** Well, I think the whistleblowing system as you call it,
12 Freedom to Speak Up --
13 **Q.** Yes.
14 **A.** -- again I emphasise is not there to provide another
15 means of investigating things. It's there to facilitate
16 information getting to the people who ought to be doing
17 the investigating and if they are not, they shouldn't be
18 internally, then outside.
19 So clearly the protocol we have been talking about
20 would need to include what you would do in a neonatal
21 unit about referral to, say, the Medical Examiner or the
22 Coroner or the police or the Child Death Review process
23 or all of the above and so you can imagine because this
24 is a rare event that it would be pretty quick that
25 a guardian might well decide maybe even some external

1 advice about what should be done.
2 **Q.** I think one of the watchwords that you mention
3 repeatedly is the need to act swiftly when concerns are
4 raised particularly if they engage patient safety
5 issues?
6 **A.** Well, I think that's -- that's right. I mean the speed
7 required will -- will depend on it. But something like
8 this clearly is likely to need speed but equally caution
9 because, you know, unintended consequences can flow.
10 So it needs to be got into the hands of the people
11 who are expert in dealing with this sort of issue, which
12 won't be the guardian and it won't be the whistleblower
13 probably, but the point about the guardian is they will
14 know where it should go.
15 **Q.** The last subtopic I would like to ask you about which
16 draws on Professor Dixon-Woods evidence and also topics
17 you have talked about today is family engagement and it
18 is something which is one of your principal concluding
19 conclusions, if I can put it that way, in Part 2 of your
20 report?
21 **A.** Yes.
22 **Q.** I think you say all strategic decision-making bodies and
23 frontline staff should be required to introduce service
24 users and their representatives into their organisation
25 decision-making processes.

1 So far as this issue is concerned, speaking up, how
2 do you anticipate that working?
3 **A.** Well, one of the problems, challenges people who are
4 speaking up can face is what, you know, what should or
5 who should they be approaching, a family for instance or
6 a patient, about something that -- concerns that they
7 feel has been concealed from them and that is a not
8 infrequent event.
9 There's been at least one case in the last few years
10 where a whistleblower decided to approach a family but
11 was feeling that not enough had been done. The Trust
12 then -- this is in the public domain, that's why I can
13 talk about it -- set out a forensic investigation to
14 find out who wrote the letter, it was an anonymous
15 letter, to the family to the extent of requiring, trying
16 to get fingerprints off members of staff to do this.
17 That was eventually stopped, it's not been heard of.
18 But that's the extreme to which one Trust went when
19 a whistleblower wanted to tell a family about a matter
20 of concern.
21 So the -- clearly the duty of candour is an issue
22 which you have got this sort of concern, what do you do
23 about it? But obviously if you have got something that
24 might involve a police investigation, I am not sure
25 I would necessarily advise either the whistleblower or

1 the guardian to be immediately advising going to the
2 family to talk about it, but as a matter of general
3 principle the people who are most entitled to know that
4 there is a concern are obviously the family of
5 a recently deceased baby.
6 **Q.** So trying to translate --
7 **A.** But I think there is a tension, forgive me, a bit of
8 a tension, which I am not sure I am qualified to resolve
9 without knowing more of the facts, between the needs of
10 an investigation into a criminal matter and the needs of
11 the family to know that something is happening. There
12 is a balance to be done there as to how much you would
13 actually say to a family.
14 I mean, you might say to a family we -- there is --
15 a concern has been raised about the cause of death of
16 your child and therefore we've had to inform the police.
17 But whether you go further and say: well, we have
18 actually -- it would be unlikely to me that you would go
19 further and say: well, actually we suspect X of being
20 the perpetrator. I don't think that would necessarily
21 be appropriate.
22 **Q.** No, there may -- it is understandable that there are
23 certain instances where it might be counterproductive to
24 involve the families --
25 **A.** Yes.

1 **Q.** -- early on particularly if criminal proceedings could
2 be compromised as a result. But overall you are pro
3 I think getting the families involved in the system?
4 **A.** Definitely. I mean if a child has died of an unexpected
5 death and no one knows what the cause is, then you
6 should be involved with the family and sharing with them
7 that uncertainty and that lack of knowledge and that is
8 part of the duty of candour. They shouldn't be fobbed
9 off, as I suspect families in the past might have been,
10 with: I'm afraid that's one of those things. We don't
11 always know what the answer is.
12 They should be part of the search for an answer.
13 **Q.** And in some instances they in fact have information to
14 give?
15 **A.** Exactly, yes.
16 **Q.** This may be an issue in this Inquiry --
17 **A.** Yes.
18 **Q.** -- where parents had concerns which they never
19 articulated which, in a strange way, might have mirrored
20 those of the professionals?
21 **A.** Yes, and that of course requires huge sensitivity and
22 skill in doing that because the last thing anyone wants
23 to do is to cause unnecessary distress to people who are
24 already very distressed about a tragedy. But the fact
25 of the matter is that when an unexpected outcome has

occurred there will be distress and the family as you say will often have things to contribute.

They are -- and I have seen this time and time again in less dramatic circumstances -- the family are the experts about the well-being of their child. They know more about what their child looks like than what, even as a small baby, than a nurse will all the time and you must listen to them.

And it's true of all forms of medical care. You have got to listen to the patient, you have got to listen where there are children to their family and that is absolutely true about individual -- individual care but it is also true about dealing with system issues as well. You must involve the patients, otherwise you have a service which is providing the wrong service to the wrong people in the wrong way.

Q. Sir Robert, thank you. Was there anything else from a speaking up perspective which you would like to add?

A. I think I have spoken up enough.

MR SKELTON: Thank you.

LADY JUSTICE THIRLWALL: Thank you, Mr Skelton.

Sir Robert, enormous thanks, firstly, for providing such a detailed and thoughtful report and then being kind enough to be here for over five and a half hours to develop your evidence. You have made an enormous and

very helpful contribution to the Inquiry.

A. Thank you.

LADY JUSTICE THIRLWALL: Thank you very much indeed. We will rise now and start again tomorrow morning at 10 o'clock.

(4.39 pm)

(The hearing was adjourned until 10 o'clock, Tuesday, 1 October 2024)

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