Witness Name: Rob Behrens
Statement No. PHSO/1
Exhibits: Uploaded on Epiq
Dated: 13 March 2024

THIRLWALL INQUIRY

WRITTEN STATEMENT OF ROB BEHRENS ON BEHALF OF THE PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

I provide this statement in response to a request under Rule 9(1) and (2) of the Inquiry Rules 2006 dated 9th November 2023.

I, ROB BEHRENS, will say as follows: -

Response to Evidence

Please set out your name, address, date of birth and any professional qualifications relevant to the duties you discharge in the Parliamentary and Health Service Ombudsman.

Name: Rob Behrens
Role: Ombudsman at the Parliamentary and Health Service Ombudsman
Address: Parliamentary and Health Service Ombudsman, Citygate, Mosley Street, Manchester, M2 3HQ
Professional qualifications relevant to the duties you discharge in the Parliamentary and Health Service Ombudsman:

- BA (Hons), University of Nottingham
- MA, University of Exeter
- Honorary Doctorates, University of Worcester, and Coventry University
- Vice President of the International Ombudsman Institute Europe

- Former Chair and Honorary life member of the European Network of Ombuds in Higher Education

Please provide a brief outline of the role and responsibilities of the Parliamentary and Health Service Ombudsman.

1. The Parliamentary and Health Service Ombudsman (PHSO) makes final decisions on complaints that have not been resolved by UK Government departments, the NHS in England and some other UK public organisations.

2. In holding public bodies to account, PHSO is impartial and independent of Government and the NHS. PHSO is not a regulator, consumer champion or an advocacy service.

3. PHSO looks into complaints where an individual or group believes there has been injustice or hardship because an organisation has not acted properly or fairly or has provided a poor service and failed to put things right.

4. Usually, people should complain to the organisation first, so it has a chance to put things right. If the individual believes there is still a dispute about the complaint after the organisation has responded, they can ask PHSO to consider it.

5. PHSO shares findings from casework with Parliament to help it hold to account organisations which provide public services. Findings and recommendations are shared more widely to support improvement.

6. PHSO is accountable to Parliament and is scrutinised by the Public Administration and Constitutional Affairs Committee.

Governance and management structure

7. As Parliamentary and Health Service Ombudsman, in statute and by warrant of His Majesty, I am responsible for the sound governance and effective internal control of the Ombudsman service.

8. I am the Chair of a unitary Board which is in place to improve the governance of the organisation. The Board is made up of executives and non-executives.

9. The Board's core purpose is to make collective decisions on the organisation's strategic direction and performance. The Board scrutinises overall performance of casework, but not individual cases.

10. As Accounting Officer, I am accountable to Parliament for the stewardship of our resources. I have delegated executive responsibility to the Chief Executive for effective financial control arrangements.

11. I discharge my responsibility through assurance from the Accountable Officer and the Executive Team, and through assurance and challenge by the Board, the Audit and Risk Assurance Committee, the Quality Committee, the Remuneration and Nominations Committee and the Inclusion and Wellbeing Committee.

How we manage complaints, including those relating to neonatal care

12. We follow a three-step process for managing all types of complaints. We do not take a different approach to complaints about neonatal care.

13. When we first receive complaints via the helpline, email, post or webform, we collect details about the complainant, the person affected, the organisation and the issue. At the initial check we make sure that we can deal with the complaint and that it is ready for us.

14. Next, if we can take forward a complaint, a primary investigation is held to decide if we can resolve the complaint quickly without further investigation. This may include mediation. If the complaint cannot be resolved through a primary investigation and it meets all the criteria for further investigation, it progresses to a detailed investigation.

15. We use powers set out in the Parliamentary Commissioner Act 1967 or Health Service Commissioners Act 1993 to conduct a detailed investigation. The caseworker agrees the scope of the investigation (what it will cover) with all parties.

16. We gather and evaluate all information needed to decide on the matter agreed in the scope. This includes evidence from the complainant and organisation, and any specialist legal or clinical advice.

17. We share provisional views with all parties to make sure we have suitably considered all the evidence. Once we have made a final decision, we write to the complainant and the organisation complained about to let them know.

18. If we uphold the complaint, we make recommendations to the organisation complained about setting out what it needs to do to put things right.

19. I have a statutory responsibility for individual cases but have given authority for case activity to officers in a written delegation scheme. I act personally in complex cases and where we identify serious or repeated mistakes that may have system-wide relevance.

20. To ensure that this extensive casework is managed within a defined system of appropriate oversight, I have a detailed scheme of casework delegated authority and have appointed two Deputy Ombuds: the Chief Executive and the Director of Operations, Clinical and Legal.

Setting standards for good complaint handling

21. In 2021, we launched the NHS Complaint Standards (Exhibit RB/1 [INQ0014511]) – a model complaint handling procedure and guidance which set out how organisations providing NHS services should approach complaint handling. The Standards were developed and led by PHSO in close collaboration and consultation with NHS organisations and advocacy bodies. The Standards apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. Building on the good practice that already exists, they provide a consistent approach to complaint handling across the NHS.

22. In 2022, we published the UK Central Government Complaint Standards (Exhibit **RB/13** [INQ0014523]), developed in collaboration with central Government departments, other public bodies, and advice and advocacy groups.

23. Together with the tools and training we provide, the Complaint Standards support organisations to provide a quicker, simpler and more streamlined complaint handling service.

The Ombudsman's role in sharing learning from complaints to improve services

24. We share the lessons learned from our casework so that organisations can improve public services. We do this by routinely publishing casework decisions, regularly publishing case summaries, and through publishing insight reports and laying these before Parliament.

25. We also work with Parliament's Select Committees and MPs to hold the Government and public services to account for delivering improvements.

Complaint Information and Statistics

26. While the PHSO receives complaints about both the NHS and Government bodies, the majority of complaints relate to the NHS. As explained above, the role of the PHSO in regard to NHS complaints is wide ranging, although the majority relate to clinical care.

27. The table below shows the numbers of health complaints received by PHSO:

Financial Year	Number of NHS Complaints
2011/2012	14615
f2012/2013	16341
2013/2014	17964
2014/2015	19535
2015/2016	21306
2016/2017	23130
2017/2018	24616
2018/2019	22539
2019/2020	24560
2020/2021	18727
2021/2022	26907
2022/2023	26565

28. In regard to complaints within this number which relate to "neonatal care", this is slightly more complicated to report. In the reporting periods between the financial years 2011/12 – 2016/17, complaints received by PHSO were recorded in a case management system called "Visual Files". This system had no specific flag available for neonatal complaints. Due to the passage of time, much of the information recorded on the system has been deleted under the retention policy and in line with appropriate standards and practice on the disposal of information no longer required.

29. In the reporting period for the financial years 2016/17 – 2019/20, the system in place had limited capability to categorise complaints, which meant neonatal complaints were not identified separately to maternity complaints in general. Our new system has more sophisticated analysis tools to allow categorisation and identification of themes in complaints.

30. Given the above, in order to assist the Inquiry as far as possible, we reviewed how we categorise health cases and identified the terms we felt would ensure we identified all neonatal cases. Having done so, we have undertaken searches across the systems, checking the "neonatal" category but also searching within the free text field, as "neonatal" was not always a specific category open to selection. The searches we undertook were therefore for the following:

Medical Condition
Neonatal

Complaint Summary Keywords
Neonatal
neonate
babycare
premature child
premature baby
premature son
premature daughter

31. As a result of these searches, we identified 68 cases – 65 closed cases and three ongoing cases. Of these, we confirm that none involve the Countess of Chester Hospital. In order to assist the Inquiry, we have prepared a table of the 65 closed cases (Exhibit **RB/24** [INQ0014534]) a brief summary of the complaint and our decision. Where a case was not upheld, we have noted either the finding or the reason for closure, as applicable.

Countess of Chester Hospital

Complaints about the Countess of Chester Hospital (CoCH)

32. We have received no complaints about the care of babies at the COCH's neonatal unit between June 2015 and June 2016 (inclusive).

Press statements

33. As requested, we have set out below all press statements with relevance to the Inquiry's terms of reference within the period being considered, including statements relating more generally to the themes of the inquiry (not only Countess of Chester NHS Trust).

34. Press release dated 27 September 2023 (Exhibit RB/33 [INQ0014543]) on University Hospitals Birmingham NHS Foundation Trust (UHB) review into culture:

Rob Behrens: "Patient safety must be a priority, but for that to happen, the Trust has to listen to its staff and patients, accept accountability, and learn from its mistakes. It has made a start, but there is much work to do to before we see real change and a shift in the culture of fear that has been instilled at University Hospitals Birmingham Trust. It is clear from this review that dedicated staff do not feel safe raising concerns in case there are repercussions. The people who work at the Trust are proud to deliver expert care to the patients they serve. They deserve to work in a safe environment, where they are treated fairly, feel valued and are confident that when they raise concerns, those concerns are addressed."

35. Press release dated 30 August 2023 (Exhibit RB/34 [INQ0014544]) on Lucy Letby Inquiry statutory status:

Rob Behrens: "We welcome the Letby inquiry being given statutory status. It is only right that there is such an inquiry into how she was able to carry out such heinous crimes for two years before her employer raised concerns with the police. This is the only way the families can get to the truth of what happened. It's the very least they deserve.

"Having said that, we still need a thorough, independent review of NHS leadership, accountability and culture, and it needs cross-party support. The culture of fear and defensiveness within the NHS is not isolated to this case, it is a widespread problem which our Broken Trust report (Exhibit RB/35 [INQ0014545]) laid bare. These recent events mean our recommendations take on even more urgency.

"This is the moment to reset the culture of the NHS which can only happen if we fully explore the problems and potential solutions. This culture of fear and defensiveness needs to change and be replaced by one where patient and staff voices are heard."

36. Interview dated 29 August 2023 with BBC Newsnight on Norfolk and Suffolk Mental Health Trust and wider NHS culture.

Rob Behrens: "I come across a culture in the health service time and time again where managers say to me, if you're critical about what we do, it will scare people off and that's not going to help us. Now I understand that, but I also know that at the heart of the health service is public trust. If people are not told the truth about what has happened, then their relationship with the health service will be in further decline than it already is.

"We know that Trusts will do a great deal when they are in a difficult position to try to preserve their reputation, sometimes at the avoidance of the facts. We have to get together to try and change the culture of the health service, so that people feel more confident about accepting criticism."

37. Interview dated 23 August 2023 with ITV (Exhibit RB/36 INQ0014546]) about NHS whistleblowing in the context of the Lucy Letby case:

Rob Behrens: "Whistleblowers themselves do not believe they are safe to go public. Those that do are in for a long and very difficult road because the law on whistleblowing is too weak and too much in favour against the body who has blown the whistle.

"I think the whistleblowers behaved with great integrity. They were very strong. When you consider they were threatened and bullied, they didn't stop raising the issue."

38. Press release dated 18 August 2023 (Exhibit RB/37 [INQ0014547]) on Lucy Letby verdict:

Rob Behrens: "We know that, in general, people work in the health service because they want to help and that when things go wrong it is not intentional. At the same time, and too often we see the commitment to public safety in the NHS undone by a defensive leadership culture across the NHS.

"The Lucy Letby story is different and almost without parallel, because it reveals an intent to harm by one individual. As such, it is one of the darkest crimes ever committed in our health service. Our first thoughts are with the families of the children who died.

"However, we also heard throughout the trial, evidence from clinicians that they repeatedly raised concerns and called for action. It seems that nobody listened, and nothing happened. More babies were harmed, and more babies were killed.

"Those who lost their children deserve to know whether Letby could have been stopped and how it was that doctors were not listened to, and their concerns not addressed for so long. Patients and staff alike deserve an NHS that values accountability, transparency, and a willingness to learn.

“Good leadership always listens, especially when it’s about patient safety. Poor leadership makes it difficult for people to raise concerns when things go wrong, even though complaints are vital for patient safety and to stop mistakes being repeated.

"We need to see significant improvements to culture and leadership across the NHS so that the voices of staff and patients can be heard, both with regard to everyday pressures and mistakes and, very exceptionally, when there are warnings of real evil.”

39. Press release dated 30 June 2023 (Exhibit RB/38 [INQ0014548]) on Well-Led review into UHB:

Rob Behrens: “This is another hard read for the Trust and its service users, confirming what I have been saying about patient and staff welfare and the culture at University Hospitals Birmingham. It’s a cause of real discomfort to see that staff are still concerned about bullying, cronyism and the dominance of a clinical patriarchy.

“Staff are still concerned about speaking out for fear of repercussions, and the Trust is secretive and defensive. The legacy of defensiveness clearly lives on.

“Ultimately, I want to make sure patient safety incidents are not repeated. We have seen some improvements when working with the Trust, but it isn’t enough.

“The Trust has started to acknowledge its failings and says it is aware of the need to accept accountability and learn from its mistakes. It now needs to back the words up with actions. There must be significant improvements to its culture and leadership, and, above all, the Trust must listen to the voices of staff and patients. We cannot have more tragedies.”

40. Press release dated 29 June 2023 (Exhibit **RB/2** [INQ0014512]) on Broken Trust patient safety report:

Rob Behrens: "Mistakes are inevitable. But whenever my office rules that a patient died in avoidable circumstances, it means that incident was not adequately investigated or acknowledged by the Trust.

"Every time an NHS scandal hits the front pages, leaders promise never again. But the NHS seems unable to learn from its mistakes and we see the same repeated failings time and time again. Our report looks at the reasons for the continued failures to accept mistakes and take accountability for turning learning into action. We need to see significant improvements in culture and leadership. However, the NHS itself can only go so far in improving patient safety. One of the biggest threats to saving lives is a healthcare system at breaking point.

"The Government says patient safety is a priority but, if it means this, the NHS must be given the workforce capacity it needs. We need to see concerted and sustained action from Government to support NHS leaders to prioritise the safety of patients. Patient safety must be at the very top of the agenda."

41. Comments published by the Guardian dated 23 May 2023 (Exhibit **RB/3** [INQ0014513]) on mental health patients and sexual assaults within the NHS.

Rob Behrens: "We know that not only do mental health patients often not feel safe when receiving care, but they are not told how to complain about their experiences. If people are not empowered to speak up about their concerns, problems of safety will continue, and the situation will not improve."

42. Press release dated 31 March 2022 (Exhibit **RB/4** [INQ0014514]) on Donna Ockenden report into serious failings in maternity care at Shrewsbury and Telford NHS Trust:

Rob Behrens: "These women and their families were let down by shocking levels of maternity care with devastating consequences. What exacerbates the catalogue of errors over many years is that the voices of victims and the families were never heard, and they were even blamed for the outcomes. That is disgraceful. This report should be a wakeup call for maternity care services and Trusts. I echo Donna Ockenden's view that maternity care should be properly funded; staff well trained; and, when things do go wrong, Trusts must listen to the people affected and learn from their mistakes. This further highlights the urgent

need for PHSO to be given powers of own initiative by Parliament, which would enable us to look into systemic issues such as this, without having to receive a complaint about it first."

43. Press release dated 28 March 2023 (Exhibit **RB/5** **INQ0014515**) for launch of PHSO's maternity spotlight report:

Rob Behrens: "These cases are extremely distressing. People should be able to trust that the care they receive during what should be one of the happiest times of their lives will be safe, effective, and compassionate.

"Sadly, this is often not the case. Failures in maternity care can have a devastating impact on women, their babies and their families, and that impact can be long-lasting.

"Expectant and new parents are being failed right across the country, and very often in the same ways. The fact that we are still seeing the same mistakes over and over again shows that lessons are not being learned. This is unacceptable. There needs to be significant improvements and change."

"Everyone has the right to complain if they receive poor care. I want to assure patients and families who have experienced something like this that their voice matters.

"One of the main reasons people come to the Ombudsman is because they don't want others to go through what happened to them. By sharing their experience, they can drive improvements to help stop mistakes happening again and make maternity services safer for everyone."

44. Press release dated 28 March 2023 (Exhibit **RB/6** [INQ0014516]) on NHS Birmingham and Solihull Integrated Care Board review into University Hospitals Birmingham NHS Foundation Trust.

Rob Behrens: "This report will make hard reading for the new leadership and sets the scale of the challenge they face. It backs up our concerns about University Hospitals Birmingham in terms of culture and patient and staff welfare. While we have seen some improvements when working with the Trust, as the report makes clear we are still dealing with a legacy of defensiveness and reluctance to accept criticism that needs to be addressed.

"We have a shared aim of ensuring that patient safety incidents are not repeated, but for

that to happen the Trust must start to accept accountability and learn from its mistakes, instead of shying away from criticism. The Trust must start to implement these recommendations and make significant improvements in its culture and leadership. This is essential so people living in the West Midlands can access the best possible care with confidence."

45. Press release dated 14 March 2023 (Exhibit **RB/7** [INQ0014517]) on significant concern about culture at University Hospitals Birmingham (UHB):

Rob Behrens: "Our decision to trigger the Protocol was not taken lightly, but we had significant concerns about the Trust. It's vitally important that the NHS learns from its mistakes. To do that there needs to be a culture of openness, not defensiveness. We need to see significant improvements in culture and leadership and how the Trust engages with our investigations.

"I'm extremely disappointed that NHSE denied us the opportunity to contribute to its review. It's hard to see how the review can be evidence based if it doesn't consider all the evidence. It raises real concerns around the completeness and transparency of these reviews.

"We all share the same goal in wanting to see improvements at UHB so that people living in the West Midlands and using its services can access the best possible care with confidence. Working together and feeding our evidence and expertise into those reviews is by far the best way to achieve that goal."

46. Rob Behrens interview on BBC Newsnight dated 11 March 2023 about concerns over leadership and culture at University Hospitals Birmingham (UHB)

Rob Behrens: [At UHB we see] a lack of cooperation, a failure to engage with the Ombudsman, in order to resolve cases and learn from them. The Trust is continuously late in providing us with the evidence we have requested, they have rejected our draft findings, and when we had meetings to take the issues forward, under their previously leadership they were aggressive and they failed to understand the seriousness of the issues. There was no learning culture that we could see in the organisation at all and that is very serious indeed because the issues are about patient safety.

"After we triggered the protocol, we were told by NHS England that we would be invited to participate in the second of those reviews and subsequently that invitation was withdrawn.

My concern is a general concern that the NHS is not good at commissioning independent reviews to make sure that is properly learning from what has happened. I need to be reassured that in this case that is not also the case, but I am sceptical."

47. Times article dated 6 March 2023 (Exhibit **RB/8** [INQ0014518]) about a hospital changing medical records.

Rob Behrens: "Too many leaders are interested in preserving the reputation of their organisation, rather than listening to citizens who have legitimate complaints to make. There is a deep reluctance to explain and give an account of what you do in the health service or the public service for fear of retribution. The things that really get to me are the avoidable deaths of babies in the health service — dying because there's been poor coordination or they'd been wrongly diagnosed, or the parents hadn't been listened to. That is shocking.

"There is an inability for lots of people to be able to say what constitutes a danger to public safety in the health service. This reflects the defensiveness of the existing culture. That has to be addressed. That is a big issue."

48. Press release dated 27 February 2023 (Exhibit **RB/9** [INQ0014519]) on culture of the NHS in relation to eating disorders:

Rob Behrens: "It is heart-breaking to see repeated mistakes and tragedies like this happening again and again. We need to see a complete culture change within the NHS, where there is a willingness to learn from mistakes.

"The Government also needs to fulfil its promise to treat eating disorders as a key priority so we can see meaningful change in this area and make sure patients receive the quality of care they deserve."

49. Comments published by the Independent dated 10 February 2023 (Exhibit **RB/10** [INQ0014520]) on leadership concerns at UHB:

Rob Behrens: "There needs to be significant improvements in culture and leadership at the Trust." He also raised concerns that the trust had failed to "fully accept or acknowledge" the impact of findings from investigations on patient safety.

50. Blogpost by Rob Behrens dated 13 October 2022 (Exhibit RB/11 [INQ0014521]) on the role of an Ombudsman and NHS culture:

Rob Behrens: "Ultimately, when things go wrong, we want people to feel that their concerns are taken seriously and addressed, and that lessons are learned. That requires a culture of embracing complaints. Rather than a culture of blame or fear, we want to see Government departments and the health service."

51. Blogpost by Rob Behrens dated 21 October 2021 (Exhibit RB/12 [INQ0014522]) on Freedom to Speak Up Guardians and changing NHS culture.

Rob Behrens: "If there is a blame culture, people are not open about mistakes and the opportunity to learn and improve is lost. Indeed, negative consequences may cause performance to decline further.

"Speaking up, on the other hand, is about learning and improving. A speaking-up culture is one where people are able to make suggestions, constructively criticise and be open about errors without fear of reprisal. Organisations with a strong speaking-up culture listen to employees and learn from failings so that services can improve. The real issue is not whether mistakes are made, but how we react to them when they are made."

52. Press release dated 19 March 2019 (Exhibit RB/14 [INQ0014524]) on response to the Care Quality Commission's Learning from deaths report:

Rob Behrens: "'Time and time again we find NHS investigations into avoidable deaths inadequate, causing further suffering to families who have lost their loved ones. People shouldn't have to come to the Ombudsman to establish what has happened to their loved ones, as health services should be able to carry out high-quality investigations and learn from what went wrong. The CQC's Review shows some welcome signs of progress but the NHS must encourage a more open culture, where staff do not fear reprisals, to improve the quality of its investigations and learn from mistakes."

53. Press release dated 19 December 2018 (Exhibit RB/15 [INQ0014525]) on PHSO's Blowing the whistle report:

Rob Behrens: "The public and NHS staff must have confidence that NHS leaders are fit and proper to do the job and that whistle-blowers will not be penalised for raising concerns.

"We need fair, transparent and proportionate oversight that stops leaders who have committed serious misconduct from moving around the NHS and makes them accountable for their actions."

54. Press release dated 23 January 2018 (Exhibit **RB/16** [INQ0014526]) on proposed Health Service Safety Investigations Bill:

Rob Behrens: "Our casework demonstrates all too often how defensiveness can inhibit NHS Trusts from identifying tragic mistakes and learning from them. A key function of the Health Service Safety Investigation Branch (HSSIB) is to provide an impartial safe space for this learning to take place so it's vital that it is wholly independent from hospitals. If the government gets this right, HSSIB can make an important contribution to improving patient safety."

55. Press release dated 13 December 2016 (Exhibit **RB/17** [INQ0014527]) on CQC review of NHS investigations into deaths:

(Previous Parliamentary and Health Service Ombudsman) Julie Mellor: "Time and time again we find NHS investigations into deaths inadequate, causing further suffering to families who have lost their loved ones. Robust and effective investigations can only happen if NHS staff are properly trained. This report is a golden opportunity for NHS leaders to learn from mistakes and encourage an open, honest working environment where NHS staff do not fear reprisals."

56. Press release dated 19 July 2016 (Exhibit **RB/18** INQ0014528]) on culture change in how the NHS investigates avoidable deaths:

Julie Mellor: "We hope that this case acts as a wake-call up for NHS leaders to support a no-blame culture in which leaders and staff in every NHS organisation feel confident to find out if and why something went wrong and to learn from it. The new Health Safety Investigation Branch (HSIB) is a step in the right direction but will only investigate a small number of cases.

"We want to see a national accredited training programme for people carrying out NHS investigations and for this to include clarity about independence and accountability."

57. Press release dated 1 March 2016 (Exhibit RB/19 [INQ0014529]) on PHSO's report into lack of answers for NHS complaints:

Julie Mellor: "The NHS provides an excellent service for thousands of people every day, which is why when mistakes are made it is so important that they are dealt with well.
"When people complain to public services, they deserve answers. If mistakes are made, an open and frank apology should be given and action should be taken to stop it from happening again.

"Unfortunately, we are seeing far too many cases where grieving families are not being given answers when they complaint to the NHS, forcing them to endure more anguish and distress."

58. Press release dated 7 January 2016 (Exhibit RB/20 INQ0014530]) on the appointment of Dame Eileen Sills DBE as the first National Guardian for speaking up safely within the NHS:

Julie Mellor: "Our casework shows that the NHS still has a long way to go to create an open and transparent culture. Our recent report on the quality of NHS investigations into avoidable death and harm revealed that distraught families are being met with a wall of silence when they seek answers as to why their loved one died or was harmed. This new role will help create the culture change the NHS so desperately needs. It is vital that staff are empowered to speak up so that the NHS learns from mistakes."

59. Press release dated 16 December 2015 (Exhibit RB/21 [INQ0014531]) on PHSO's response to the MBRRACE-UK report into stillborn and newborn death rates for NHS trusts:

Julie Mellor: "Most nurses and midwives work very hard to provide the best possible care for patients but there is still a worrying variation in the quality of maternity care across the NHS. Our own casework shows that, too often, patients don't feel listened to and, as a result, opportunities to improve services are missed. It's absolutely right that hospitals should investigate higher incidents of stillbirth and newborn baby deaths to make sure they learn from these tragedies and improve their services for others."

60. Press release dated 8 December 2015 (Exhibit RB/22 [INQ0014532]) on review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged:

Julie Mellor: "Parents and families are being met with a wall of silence from the NHS when they seek answers as to why their loved one died or was harmed. Our review found that NHS investigations into complaints about avoidable death and harm are simply not good enough. They are not consistent, reliable or transparent, which means that too many people are being forced to bring their complaint to us to get it resolved. We want the NHS to introduce an accredited training programme for staff carrying out these investigations as well as guidance on how they should be done, so the public can be confident that when someone is needlessly harmed it has been thoroughly investigated and answers provided, so that action can be taken to prevent the same mistakes from happening again."

61. Press release dated 22 September 2015 (Exhibit RB/23 [INQ0014533]) on PHSO's report on the top three reasons for hospital complaints:

Julie Mellor: "We know that there are many factors that influence the number of complaints hospitals receive, such as organisational size, demographics and whether they actively encourage feedback from patients. I strongly believe that NHS leaders should welcome feedback from patients and recognise the opportunities that good complaint handling offers to improve the services they provide. We are publishing this data to help hospital trusts identify problems and take action to ensure trust in the healthcare system remains high."

62. Press release dated 19 August 2015 (Exhibit RB/25 [INQ0014535]) on PHSO's report on human cost of poor public service in the NHS:

Julie Mellor: "Often people complain to us because they don't want someone else to go through what they or their loved one went through. This report shows the types of unresolved complaints we receive and the human cost of that poor service and complaint handling. Many of the complaints that come to us should have been resolved by the organisation complained about. Complaints provide an opportunity for learning and improvements and should be embraced at all levels of the organisation from the Board to the frontline."

63. Press release dated 11 February 2015 (Exhibit RB/26 [INQ0014536]) on Robert Francis whistleblowing statement:

Julie Mellor: "I welcome Sir Robert Francis' focus on 'just culture' which looks at whether the safety issue has been addressed rather than who is to blame. We are delighted the description we developed with patients of their expectations for raising concerns and complaints will be adapted to apply to NHS staff. This puts patients and whistleblowers at the heart of the way safety concerns are dealt with."

64. Press release dated 20 October 2014 (Exhibit RB/27 [INQ0014537]) on PHSO's systemic investigation into quality of NHS investigations of avoidable harm:

Julie Mellor: "When public services fail, it can have serious effects on us as individuals. We know that when people complain, they often want three simple things: an explanation of what went wrong, an apology and for the mistake not to be repeated.

"We know in other industries like aviation and construction when things go wrong, they investigate to find the root cause, not to determine blame. They design and deliver services based on reducing or eliminating mistakes.

"Our casework indicates that there is a wide variation in the quality of NHS investigations into serious cases such as complaints about potential avoidable harm. These include failure to explain fully what happened and why, inadequate involvement of the complainant and a lack of independent clinical input.

"That's why we will examine our casework, including more than 250 cases of potential avoidable deaths. We will analyse whether an investigation would have been appropriate but did not take place or when an investigation took place but was not of a high enough standard.

"We will work with experts across health and other sectors to gather evidence of best practice and areas of improvements and will make recommendations for system wide change to the leadership and delivery of patient safety. We will publish our initial findings early next year."

Comments on Section C of the Terms of Reference

Patient safety and relevance to the Letby case

65. What happened at the Countess of Chester hospital was an appalling tragedy. It is essential that this inquiry is able to establish the facts in order to answer the questions of families and to honour the lives of those who died. The inquiry must also ensure that the NHS learns from these events and commits to changing in response to its findings.

66. It is extremely rare for someone to act with the intent to harm in the NHS. My Office deals with thousands of complaints about the NHS each year and while the errors we find can have tragic consequences, they are typically the result of failures of cultures, systems, processes or skills, not malice. It right that we recognise and appreciate the dedication, integrity and empathy of many thousands of NHS medical and support staff.

67. What the Letby case has in common with consideration of wider patient safety failings in the NHS is the question of how safety concerns are heard, responded to and escalated. I welcome that Section C of the terms of reference for this inquiry extends beyond the circumstances of the Letby case to look more widely at the safe care of babies and a consideration of NHS culture.

68. As detailed above, we did not receive any complaints about the care of babies at the Countess of Chester OCH's neonatal unit between June 2015 and June 2016. My evidence draws on the overall picture of NHS activity that I see through my Office, unless otherwise stated.

Hearing concerns and communicating well – patients and families

69. Earlier this year, my Office published *Broken trust: making patient safety more than just a promise* (Exhibit RB/35 [INQ0014545]), which drew on findings from the 22 cases in the past three years where we made a finding of avoidable death. We published this report ten years on from the landmark Francis Inquiry into failings of care at Mid Staffordshire NHS Foundation Trust.

70. Despite significant developments and investment in patient safety over the past decade, I am concerned about how far there is still to go to truly embed a just and learning culture across the NHS. Frustratingly, we see similar failings in our casework today to those we have highlighted many years previously. For example, our recent *Spotlight on sepsis*

(Exhibit RB/28 [INQ0014538]) report drew attention to similar issues to those identified in our *Time to Act* (Exhibit RB/29 [INQ0014539]) report ten years earlier.

71. One of the themes that emerged when we looked at common failures for *Broken Trust* (Exhibit RB/35 [INQ0014545]) was not listening to patients and families. These include examples where families and carers felt their voices were ignored at critical points during treatment, leading to delays and missed opportunities to prevent harm. For example, in one case where we made a finding of avoidable harm, a complainant described how he had to persuade staff to admit his mother after she had attended the Trust's emergency department multiple times. In our investigation, we found evidence that staff doubted the patient's symptoms and failed to appreciate the serious nature of her condition. The complainant's mother died after having a stroke in hospital. This could have been avoided if she had been diagnosed correctly and treated during an earlier admission.

72. Failure to listen to patients is a particular issue in maternity services. Since 2017, the national maternity survey has shown a downward trend in the proportion of women saying that if they raised a concern during labour and birth, it was taken seriously. The investigations into failings at East Kent Hospitals University NHS Foundation Trust found a common theme was the failure of Trust staff to take notice of women when they raised concerns.

73. More broadly, problems with communications are a common theme in PHSO's maternity work. In our recent *Spotlight on maternity care* (Exhibit RB/30 [INQ0014540]) report, we noted that in the 27 maternity complaints that we upheld between 2020 and 2022, more than half involved communications issues. In one of the cases we highlighted, where a complainant sadly miscarried her daughter, healthcare professionals did not discuss pain relief options or explain what medication they were giving her. There was poor communication about what to expect when experiencing a miscarriage in the second trimester. This caused the mother a lot of distress because she did not know what was happening or if her daughter would survive. After the complainant left the hospital, the mortuary service did not communicate the date for her daughter's funeral, buried her without the family there, and then gave incorrect information about where she was buried. These communication failures all compounded the complainant's distress at an incredibly difficult time.

74. The issue of not being heard has been powerfully highlighted following the case of Martha Mills who died in 2021 after contracting sepsis. Martha's parents, Merope Mills

and Paul Laity, have spoken about how difficult it was to make their concerns heard when they saw that their daughter was deteriorating rapidly. I welcome the recently accepted proposals for 'Martha's Rule' to ensure patients, families, and carers have access to a 24/7 rapid review from a critical care outreach team if they are worried about the patient's condition. I also welcome the call for a structured approach to obtaining information relating to a patient's condition directly from patients and their families at least on a daily basis. These procedural changes are important steps towards a vital cultural shift whereby families and patients can work in partnership with the NHS to deliver safe healthcare.

Hearing concerns – staff

75. While I have no knowledge of the culture at the Countess of Chester hospital that may have made staff more or less likely to report criminal activity specifically, we do know that there are widespread issues with staff feeling able to speak up about their concerns within the NHS.

76. The most recent NHS staff survey found declines on all measures relating to raising concerns in terms of both clinical safety and speaking up more generally. Freedom to Speak Up Guardians – the individuals charged with ensuring NHS workers can speak up about any issues impacting on their ability to do their job – have also indicated a worsening picture. In the latest survey, over a quarter (26%) of Guardians said the 'speak up' culture in healthcare had deteriorated. Two-thirds of respondents (66%) perceived the fear of detriment (where people are disadvantaged or subject to demeaning treatment for speaking up) as having a noticeable or very strong impact as a barrier to workers in their organisation speaking up.

77. There are too many cases of individuals paying a heavy price for raising concerns. The National Guardian's annual report states there were more than 1,000 cases of detriment reported to Freedom to Speak Up Guardians in 2022/23. Many NHS whistleblowers have described the severe impact on their mental health and in some cases the end of their NHS careers. These visible examples serve to undermine other well-intentioned efforts to transform the NHS into an open, transparent organisation that listens to staff, particularly about safety concerns.

78. A further barrier identified by Freedom to Speak Up Guardians results from the unintended adverse consequences of strict professional hierarchies – nearly 60% of

those surveyed identified such hierarchies as having either 'very strong' or 'noticeable' impact as a barrier to speaking up. This is a particular concern in the context of maternity and neonatal settings. The report on maternity and neonatal failings in East Kent Hospitals University NHS Foundation Trust highlighted dysfunctional relationships between obstetricians and midwives and noted specifically that "hierarchy disempowered staff from speaking up". These team dynamics must be addressed if we are to see the development of an open, learning culture in maternity and neonatal care settings.

Learning from complaints and supporting complainants

79. NHS complaints processes are another opportunity for learning that can prevent future harm. PHSO's 2020 report, *Making Complaints Count* (Exhibit **RB/31** [INQ0014541]), examined the state of complaint handling across the NHS and UK Government. The report highlighted that public bodies still tend to view complaints negatively, rather than as a valuable source of intelligence that can be used to improve services. This can lead to responses that lack compassion and are characterised by defensiveness rather than a willingness to listen and learn.

80. We know that the process of making a complaint can itself be a source of further harm for families because of the response they receive from NHS organisations. The act of making a complaint requires a great deal of determination and energy because it is very challenging for patients and families to navigate the complex NHS landscape when they want to raise concerns and seek answers, especially given that complainants are often in a vulnerable condition resulting from service failures or even bereavement. We frequently see examples of unacceptable and unreasonable delays in responding to complaints and failure to keep families informed and updated about the progress of their case. Families we interviewed for *Broken Trust* (Exhibit **RB/35** INQ0014545]) described the process of trying to resolve their complaint with Trusts as 'long and tortuous', 'a long, dragging sequence of events' and 'very lengthy and distressing'.

81. A core function of my Office is to support improved complaint handling in the NHS. Partly this is about providing the right tools and frameworks to drive up the quality of complaints processes. It is also about encouraging senior leaders to develop a working culture that welcomes and learns from feedback.

82. We have worked with a wide range of Trusts and stakeholders to co-produce the NHS Complaint Standards (Exhibit **RB/13** [INQ0014523]) to support organisations to provide a quicker, simpler and more streamlined complaint handling service. The Standards set out how NHS services should approach complaint handling. This includes welcoming complaints in a positive way by clearly publicising how people can raise complaints in a range of ways that suit them and meet their specific needs. It also includes ensuring people know how to get advice and support when they make a complaint, for example, through sharing details of appropriate independent complaints advocacy and advice providers and any Patient Advice Liaison service (PALS) and other support networks.

83. The Complaint Standards are being embedded across the NHS and we will be reporting on the implementation of the Standards in 2024. PHSO offers advice and training to support the roll out of the Standards. This has included delivering training to independent senior advocates in maternity services - a new NHS role currently being trialled. This role plays an important part in ensuring women and families are supported in navigating the healthcare system when they have a concern about the care they and their babies are receiving. All new advocates will receive this PHSO Complaint Standards training as part of their induction training organised by Baby Lifeline.

Responding to patient safety incidents

84. As we found in our *Broken Trust* (Exhibit **RB/35** [INQ0014545]) report, the way that NHS organisations respond to concerns about patient safety is key. We have seen poor responses that fail to accept the possibility that something may have gone wrong, a reluctance to learn from mistakes, and a failure to offer meaningful apologies to bereaved families. Although I acknowledge and welcome the significant and important work underway to improve the quality of NHS investigations, at present the experience of my Office is that these are not always as thorough as they should be and do not always identify the errors we later find.

85. I am also concerned about the amount of time and attention given to scrutinising and interrogating patient safety by NHS Trusts' Boards. In some cases, a desire amongst senior leaders to protect organisational reputation can become a barrier to curious and open engagement with patient safety issues. In *Broken Trust* (Exhibit **RB/35** [INQ0014545]), we recommended that Boards should examine and discuss differences in findings between PHSO and local safety investigations. We also argued that there is a

key role for Integrated Care Boards to monitor patient safety investigations and learning responses from Trusts to help drive quality and accountability.

86. To support this, NHS leaders must be in no doubt of the priority placed on patient safety by Government and other national NHS leaders. Patient safety and investment in the culture and leadership needed to deliver safe care must be a long-term sustained priority that does not shift with the changing of political leaders.

87. It is vital that we have an oversight and regulatory system that can identify and respond to safety risks effectively. The current landscape does not support this. There are a range of bodies including HSSIB, the Patient Safety Commissioner, NHS England, NHS Resolution, the Care Quality Commission as well as more than a dozen different health and care professional regulators all playing important roles in patient safety. There are significant overlaps in function leading to uncertainty about responsibilities and fractured leadership. As outlined in *Broken Trust* (Exhibit RB/35 [INQ0014545]), I am calling on the Department of Health and Social Care to commission an independent review of the collective landscape of patient safety oversight bodies.

88. This review should include consideration of the current powers given to the different bodies with a remit for patient safety and whether they are fit for purpose. My own Office is constrained in that an individual must have complained to us for us to investigate. This limits what we can look at and can slow down the process of understanding safety risks and making recommendations for change.

89. For example, in 2019, we published *Missed Opportunities* (Exhibit RB/32 [INQ0014542]), a report based on two complaints about a mental health inpatient unit in Essex. Both cases involved young men dying shortly after being admitted to the same unit, four years apart. In looking into these complaints, we learnt that at least 20 other families had lost loved ones in strikingly similar circumstances: young men dying soon after being admitted to this particular unit in Essex. Because my Office does not have powers to look into issues unless we have received a specific complaint, we could investigate only the two complaints we had received. We could not widen the scope of our investigation to include the pattern of deaths on the unit, leaving grieving families without answers. Families have since had to wait four more years for a statutory inquiry into these deaths to begin in earnest.

90. Justice for individuals and learning for systems should not be dependent on whether a complaint comes to my Office. There will always be individuals whose personal circumstances mean they are unable or unwilling to bring a complaint to PHSO. Own initiative powers would give my Office more flexibility to investigate patient safety concerns at the earliest opportunity and bring PHSO into line with other Ombudsman schemes in the UK and globally.

The accountability of senior managers

91. The regulation of managers has been widely discussed in the wake of the Letby case. Although I welcome this debate, it is important to note that regulation alone would not have been enough to prevent any leadership behaviours at the Countess of Chester hospital which may have contributed to Lucy Letby continuing to harm babies after concerns were first raised.

92. Key leaders involved in the Letby case were already regulated professionals (Nursing Director, Medical Director, and CEO) and yet Letby's crimes went unaddressed for too long. We should be wary of any false binary between clinicians and managers in these discussions. One in three clinically trained staff are engaged in management activities of some kind. And a third of NHS chief executives have clinical qualifications. When registered clinicians are in management and leadership roles, codes of professional practice still apply.

93. While further regulation may not have made a material difference in the Letby case, I welcome the opportunity to examine whether the right systems are in place to hold senior managers to account for their behaviour while working in the NHS. This is a separate but important question in its own right.

94. Government should act on the recommendation from the Kark review to implement a mechanism for disbarring NHS directors following serious misconduct. Kark's recommendations were intended as a package of measures and the suggested system for disbarring is important part of the aim to ensure there is no 'revolving door' in the NHS for leaders who are unfit for such roles due to past conduct. I welcome the announcements last summer that the Government intends to look at this recommendation again.

95. In terms of a new regulatory system that goes beyond the Board level positions that Kark was asked to look at, I agree that public consultation to explore further accountability is necessary. However, I think this needs to be done with several caveats in mind.

96. First, there must be wide-ranging and careful consultation to avoid unintended consequences. It is already challenging to recruit and retain high-performing senior NHS leaders, as there is a small pool of candidates for this demanding work. It would therefore be essential to ensure that regulation supports the professionalisation of these careers rather than driving competent people away from them.

97. Second, any regulatory framework must be strictly independent of DHSC and NHS England. Regulation absolutely cannot be delivered by the same bodies that are accountable for the performance of NHS organisations. This is already an accepted principle for all other regulated professions that work in the NHS.

98. Third, it would be important to consider how further regulation would or would not align with management arrangements in other parts of the public sector to avoid further entrenching silos between health, local government and housing. To support better integration of local public services, senior leaders should be able to move between frontline organisations without regulation acting as an impediment.

99. Finally, we must be realistic about what such measures can achieve and the costs associated with them. Further regulation involves adding additional process and bureaucracy on to an already complex and overstretched system. Therefore, we should adopt a cautious approach and regulate further only where we can be confident that the gains will outweigh the significant costs.

100. In my view, effective regulation can indeed contribute to cultural change, but it cannot deliver it on its own. Leadership behaviours will always be the most important determinant of culture and we cannot allow a focus on regulation to distract from the urgent need to improve the quality of leadership in the NHS.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

PD

Signed _____

Dated _____13 March 2024 _____