HOUSE OF COMMONS

Health and Social Care Committee

Oral evidence: NHS litigation reform, HC 740

Tuesday 16 November 2021

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Watch the meeting

Members present: Jeremy Hunt (Chair); Lucy Allan; Paul Bristow; Barbara Keeley; Taiwo Owatemi; Anum Qaisar; Dean Russell; Laura Trott.

Questions 1 - 45

Witnesses

I: Sue Beeby, Parent; Scott Morrish, Parent; Joanne Hughes, Parent; Sir Robert Francis QC, Chair, Healthwatch England; Sir Ian Kennedy QC, Emeritus Professor, Health Law, Ethics and Policy, University College London; and Dr Sonia Macleod, Researcher, Civil Justice Systems, Centre for Socio-Legal Studies, University of Oxford.

Examination of witnesses

Witnesses: Sue Beeby, Scott Morrish, Joanne Hughes, Sir Robert Francis QC, Sir Ian Kennedy QC and Dr Macleod.

Chair: Good morning. Welcome to the first session of the Health and Social Care Select Committee inquiry into NHS litigation reform. Last year, the NHS spent a staggering £10 billion on compensation claims and legal costs related to clinical negligence claims. The total potential liabilities from all claims at the end of last year was £82.8 billion, and it is currently going up by just under £6 billion a year.

These are obviously vast sums of money for the taxpayer, and it is money that is not being spent on patient care. Is the legal process actually serving its purpose for families? Some of the biggest awards are for children born with brain injuries. You would imagine that one impact would be a big focus on reducing such injuries, but the numbers remain stubbornly high. Families complain about the time taken for things to be resolved, with a typical family waiting, on average, 11 and a half years for a case to be resolved.

Those are the issues we are going to look at in this inquiry. Later we will be helped by three eminent legal experts, in the form of Sir Ian Kennedy, Dr Sonia Macleod and Sir Robert Francis. First, we want to hear from three families who have experience of what happens in the NHS when errors are made. Joining us are Scott Morrish, whose son Sam died from sepsis at the age of three; Joanne Hughes, who lost her daughter Jasmine when she was 20 months old due to failures in her care; and Sue Beeby, who used to work for me as a special adviser in the Department of Health and whose son Jasper died aged two after he suffered a brain injury at birth.

Lucy Allan will kick things off by asking Scott some questions.

Q1 **Lucy Allan:** Thank you very much for coming here today, Scott. Your story is terribly sad, but the work you have done subsequently is commendable. I would like to thank you for that. Could you start by describing the challenge of trying to find out the truth about what happened to Sam?

Scott Morrish: The challenge that I had imagined in the period of time after Sam died was learning to cope with his loss. What we found out quite quickly was that, as we tried to understand that loss and why Sam had died, there was a massive reluctance to look at the details of what had happened on the night he died.

In my mind, it should have taken six or seven days to establish what had happened and why he had died. It ended up taking six months, initially, to get a form of local investigation response, but it took six and a half years to find out more comprehensively and accurately what had happened. It started with a report after six months that said that Sam's death was not avoidable and nothing could have been done. Six and a half years later, we established not only that it was avoidable, but that there were a whole stack of things that could have been done, including dealing with the aftermath of his death.

Q2 **Lucy Allan:** You were told very early on that the death was unavoidable and nothing could have been done.

Scott Morrish: We were told that he was unlucky. There was a flu pandemic, it was bad weather, the system was under stress and, essentially, he was unlucky. Nothing could have been done.

Q3 **Lucy Allan:** What made you take that further? How did you find the strength to say, "I'm not accepting that"?

Scott Morrish: I am not sure that it was strength—stubbornness, maybe. The complete inability of the system at almost every point to answer basic questions is what fuelled us to push further. What they told us did not make sense. It did not fit what we knew. It did not include a lot of what we knew and had told them. Those holes in the understanding that they were willing to acknowledge let us fall through the system and lose confidence in safety. We ceased to feel safe.

Q4 **Lucy Allan:** Did they sit down with you at an early stage to go through everything that had happened? Did they show willingness to engage?

Scott Morrish: There was willingness to engage. To their credit, the GP sat down with us very early and was apologetic. There was no failure to apologise. People within the hospital sat down with us, but that was more at our request. We wanted to meet them because we wanted to know how to move forward. It was never an invitation the other way around.

It is not necessarily a reluctance to meet. There is an awkwardness about meeting. It is a really difficult thing for them to do, as well as for us. It was the next bit; going further and saying, "Let's meet, let's get past the apology and let's actually understand the full picture of what happened," seemed to be beyond their capacity.

Q5 **Lucy Allan:** In order to get to the truth, did you ever think about pursuing a clinical negligence claim?

Scott Morrish: I would have done everything on earth to avoid that.

Q6 **Lucy Allan:** Why was that?

Scott Morrish: I might be wrong, and I might be corrected later, but I saw litigation only as a means of reducing Sam's death to a financial equation and I never wanted to do that. I also thought that it would be toxic. My goal all along was to be able to sit and have frank conversations, and I did not see that that would ever be possible if we went down the litigation route.

Q7 **Lucy Allan:** From the campaigning work that you have done subsequently, do you still hold the view that clinical negligence is not useful for patients or families in seeking information or redress?

Scott Morrish: I have never said that it is not useful. In some cases, it probably is. It had no place in my case. Clinical negligence, and reform of clinical negligence, needs to be seen in a much broader context, which includes the failure to investigate locally, the failure of complaints handling at almost every level and what I would describe as regulatory failure across the board. The sort of siloed regulation that we have is just not capable of spanning a patient's journey.

Q8 **Lucy Allan:** During the time you have been working in this area, have you seen the defensive culture—the blame culture—diminish?

Scott Morrish: No.

Q9 **Lucy Allan:** Is it something that is still fundamentally there?

Scott Morrish: I do not think it has changed at all.

Q10 **Lucy Allan:** Not at all?

Scott Morrish: No. I think the talk about it has changed. The language used has changed. It is a bit like greenwash when you are thinking of carbon.

Q11 **Lucy Allan:** Were the terrible tragedy to happen to Sam again today, do you think that you would be treated in the same way?

Scott Morrish: For clarity, it is worth saying that in one hospital I might be treated very well. In another, I might not. It is not a blanket statement that applies across the board. That inconsistency should be a cause for concern.

Q12 **Lucy Allan:** Do you think it is an issue that clinical negligence actually prevents people from being open and transparent about errors when they occur?

Scott Morrish: I cannot see how it helps openness. I cannot see how it helps candour. I read some of the other evidence that has been submitted suggesting that it has a very positive role to play. I cannot see that at all. I think that its sole objective may be to form compensation for patients. Beyond that, I think that the idea that it is a way of generating lessons is a fantasy.

Q13 **Lucy Allan:** How would you like to see the system improved? How could something different be put in place? Do you have some views on what you would like to see?

Scott Morrish: I come back to the idea of local investigations and complaint handling—the basic expectation for leaders throughout the NHS and, therefore, regulators, too. I would like them actually to punish cover-ups, and deal with the conspiracy of silence that forms in many cases where you could not necessarily prove a cover-up. Maybe we should think of the blame culture in much broader terms. What are the many factors that might lead to it? Clinical negligence might be one thing. The way in which complaints are done is another. I do not see the adversarial tone that flows through all of those processes as being anything other than destructive when you are looking for candour, openness and learning.

Q14 **Lucy Allan:** Is there anything else that you would like to tell the Committee about your case, the work that you are doing and what you have learned in that process?

Scott Morrish: I would like to see the example that HSIB is trying to set in safety investigations deployed across the NHS at a local level. It should not be by HSIB; that is not possible, but we should take the learning about how to conduct actual safety investigations, as opposed to accountability of investigations or compensation investigations, and run it through the system quickly. We should then make sure that the regulators are aligned in order to regulate for that behaviour. Please, when it is not delivered, punish it. If there is a cover-up, somebody needs to be held accountable for that.

Q15 **Lucy Allan:** Presumably, it should involve families like yours at each stage.

Scott Morrish: You cannot investigate a family's experience of healthcare without the family.

Lucy Allan: Thank you, Scott, for telling us about your experience and sharing those comments with us. I really appreciate it.

Chair: Thank you very much. Scott, we will come back to you, if we may. My colleague Barbara Keeley will now talk to Sue Beeby.

Q16 **Barbara Keeley:** Sue, thank you for coming in and agreeing to give evidence. I understand that in the circumstances it must be difficult at times to talk about this. Could you start by outlining your experiences of the care that you and Jasper received and what happened?

Sue Beeby: Thank you for inviting me to give evidence today. I am really grateful for the opportunity to tell you Jasper's story and to talk about our family's experience of healthcare litigation.

When we found out that I was pregnant with Jasper, a long-talked-about third child, we had no idea of the life-changing impact that he would have on us. My pregnancy was straightforward, and Jasper's birth could have been completely unremarkable had it not been for a series of catastrophic mistakes made by the hospital in the run-up to my delivery.

Four weeks before my due date, Jasper was still not head down, so I was told by my midwife to book an appointment with the hospital to discuss our options. When I spoke to the hospital, they advised me that I should wait a couple of weeks to allow the baby the chance to get into position itself, so, instead of seeing someone at 36 weeks, I finally attended a scan when I was 39 weeks pregnant.

The scan showed that Jasper was in fact head down, but despite what had previously been said at other scans, my placenta seemed to be in a low-lying position, and it looked likely that a C-section would need to be performed. However, instead of deciding on that course of action, our consultant, after checking with another doctor, suggested that we come back in the morning to be rescanned so that she could check the findings and confirm how we needed to proceed.

We attended the next morning as planned. The consultant was clearly running late. She arrived 45 minutes after our appointment time, looking flustered and unfocused. She scanned me again and confirmed what she had seen the day before. My placenta was in a low-lying position, blocking Jasper's exit, and loops of umbilical cord were sitting between his head and my cervix. The consultant told us that I would need to have a C-section and approved this course of action with another sonographer, but instead of admitting us to hospital and conducting an urgent C-section, as guidance recommended, she suggested that I be booked in for an elective C-section in the next couple of days and sent us home, advising us that if I went into labour before then we should get to the hospital as soon as possible.

That night my waters broke and the umbilical cord prolapsed. We reacted immediately. My husband Alex phoned the hospital, which sent an ambulance out to get us. It took 48 minutes from when my waters broke to when an emergency C-section was conducted—48 minutes when Jasper was deprived of oxygen. He was born floppy and unresponsive. After he was revived by midwives, he immediately showed signs of seizure. Before I had even woken from surgery, he was intubated and prepared for transfer to Addenbrooke's so that he could receive cooling treatments.

Jasper spent six weeks in intensive care. During that time, we were contacted by the hospital where Jasper was born and told that they would be conducting a risk investigation into Jasper's birth. The hospital asked us whether we wanted to be kept informed. Initially, we said that we did not. That may seem crazy now, but at the time we were so focused on Jasper and helping him to get well that we did not have time for anything else.

We might have maintained that approach if it had not been for one of the consultants involved in Jasper's care at Addenbrooke's. I remember the look of shock on her face when I told her that the doctors knew that the cord was beneath him before he was born. She did not pause for a moment, immediately telling me that we needed to take legal action against the hospital. She stressed the importance of the financial settlement for Jasper's lifelong care needs, but also the importance for both of us and the hospital of fully understanding what had gone wrong with Jasper's maternity care. Her intervention changed our approach. We contacted the hospital and asked to receive a copy of their risk investigation report. A few months later, when we came home from hospital, I got in touch with the firm of solicitors that she had recommended.

At the beginning of our litigation process, we were driven by our desire to ensure that Jasper was properly provided for throughout his life. We knew from when he was just nine days old that Jasper had suffered severe brain damage. Although the doctors were reluctant to give us a prognosis, it was clear that his quality of life would be limited.

At just five weeks old, he was diagnosed with an aggressive form of dystonia—uncontrolled movements that twisted and contorted his body. He was given meds to control them, but they made him violently and frequently sick. He missed all of the usual developmental milestones and required constant care and support to do everything. We knew from the very outset, as much as we hoped differently, that he would need lifelong care and support. It was this knowledge that drove us on—the thought that if something happened to Alex and me, Jasper would need to be able to fund the support that he needed. We pursued the case for Jasper, for his future.

Then, just weeks after the hospital admitted liability, just after his second birthday, Jasper died of pneumonia. His future had been taken from him, taken from us, and our purpose was gone. Everything seemed so unfinished. We had initially pursued a dialogue with the hospital privately about the learnings from Jasper’s care. We wanted to use their risk investigation as a catalyst for change within the trust, to ensure that what had happened to Jasper could never happen to another baby. However, when we met representatives from the trust, we were fobbed off by people who were not across the details of Jasper’s case. The meeting was not properly recorded. When we were asked to give a written summary of what we had said, our emails were ignored and no one updated us on whether action points had been completed. Two years on from Jasper’s birth, we still had no confidence that the same thing would not happen to another family, so we felt that we had no choice but to continue with the litigation.

Finally, four years after Jasper’s birth and two years after he died, we were offered the opportunity to sit down with the senior team at the hospital and representatives from NHS Resolution. Facilitated through our legal team, the mediation gave us the opportunity to tell our story, to raise issues about our care and to receive reassurances that changes had been implemented. It had taken much, much too long to happen, but it offered so much healing and helped us to find a bit of closure.

I am certain that without our legal team that meeting would never have taken place. I also know that it was our legal team, not the risk investigation, that established the full catalogue of errors in Jasper’s maternity care. It was our legal team, alongside us, who put cultural learnings from those mistakes at the heart of our mediation meetings.

Jasper was the most incredible, beautiful little boy, who brought so much joy to our lives. He was kind, gentle and patient. If he was frustrated by what he could not do, he never showed it. The way he dealt with the pain, constant sickness and all too frequent illness was humbling. In all healthcare litigation, there is an individual like Jasper—someone who had the future that should have been theirs taken from them through no fault of their own. That person, in life or death, deserves to have their voice heard. For Jasper, it was his legal team that allowed that to happen, when the hospital—the system—refused to listen.

Q17 **Barbara Keeley:** Thank you. You have given us an incredibly useful account and piece of evidence. I have a couple more questions, if that is okay. You have told us that in the clinical negligence process, your legal team was the process that established the full catalogue of errors. Overall, how did you find that process? Clearly, it has been helpful in bringing out the catalogue of errors and getting those meetings. What else did you find about the process?

Sue Beeby: When our solicitor came out to visit us, a few months after Jasper was born, he was the first person who had asked us about our experience of what had happened and the impact that it had had on his and our lives.

Q18 **Barbara Keeley:** No one in the NHS had asked you that.

Sue Beeby: The hospital conducted its entire risk investigation report into what happened with Jasper's maternity care without speaking to me or my husband. They never contacted us. They never discussed it with us. They only spoke to members of staff. That is part of the reason why they were not able to establish the full catalogue of mistakes that were made in Jasper's care.

When the legal team looked at it, they found that the hospital was inclined to believe that one doctor had made a very stupid mistake. That was very clear from the outset. They thought that that was case closed; the doctor just needed to reflect on the fact that they had made that mistake and then the hospital could continue.

Our legal investigation found that, actually, my low-lying placenta was seen at the 32-week scan and was missed by the sonographer. We were told by the hospital that we did not need to book the appointment at 36 weeks. That was a breach of guidance. We should have been seeing someone as soon as possible, because we needed to be kept in hospital from 37 weeks-plus.

The doctor we saw discussed it with another consultant and another sonographer. We were booked in for an elective C-section by a midwife and a member of the surgical team. Nobody at any stage raised the fact that I should not have been leaving the hospital. There was a series of mistakes that were not seen by the hospital; they did not even look at those things. It was our legal team, and, in fact, the legal team for the hospital, that found out much more information than we would ever have found out from the risk investigation report.

Q19 **Barbara Keeley:** You found the litigation process very positive. Was there anything about it that you would criticise?

Sue Beeby: One of the problems is that, ultimately, for children with brain injuries the most important thing is to have access to physio and all the support things they need. We received some through the NHS, but if you can supplement that with anything you can do privately it can improve outcomes. The fact that it took two years for the hospital to admit liability meant that we did not receive in time the funding that we wanted to use to improve Jasper's outcomes. That is problematic. Being able to get funds to support children within the first two years, which are imperative when you have had a brain injury, is crucial. It is better for outcomes for the patient. It is also better for the hospital, because it reduces the cost that they subsequently have to pay for care throughout a person's life.

Q20 **Barbara Keeley:** It is incredible, isn't it, that it took two years for the hospital to admit liability, and the way they behaved? What have you learned from your experience about the culture of NHS trusts? What do you want to say to the Committee about that?

Sue Beeby: Unlike Scott, I experienced no blame culture whatsoever in the hospital trust. If anything, it was a culture of complacency. They were complacent about my care. The view in the maternity department was, "Things are going to be okay. No need to worry. It will all be all right. In most cases, it is." It was the culture of complacency that we saw in response to the risk investigation report, which was, "One doctor made a mistake. These things happen." They were actually very open about the fact that a doctor had done something silly. We found no kind of cover-up, or any attempt to cover up what had happened. They simply said that a doctor had made a mistake. The issue was complacency and not being willing to look beyond that mistake to say, "Hang on a second. How was that allowed to happen?"

I worked with Jeremy for a long time on patient safety. One thing that was very clear to me was that doctors are human. They all make mistakes. What we need to do in our hospital system is ensure that there are systems and processes in place so that, if you make a mistake, patients are not harmed. If there had been people who were willing to step in and say, "This decision looks a bit odd. Why is she being sent home?", it could have been prevented. We just saw a complacent approach to our care, to the risk intervention and to the lessons that needed to be learned. It was all, "These things happen in hospitals, you know. It was an error that was very unfortunate."

Q21 **Barbara Keeley:** Awful. Is there anything else you would like to tell the Committee?

Sue Beeby: That's it, really. My main message is that I know that there is a view that litigation can be adversarial; ours was not. We had an exceptional solicitor who was very aware of the fact that our priority in the early years was caring for Jasper. He did not involve us in the case unless it was absolutely necessary. It was something that went on quietly, without our involvement at all. Then, when we lost Jasper, he knew that the most important thing for us was ensuring that no other family went through what we had. We wanted to ensure that they learned the lessons from what had happened, and that was put at the heart of the process once Jasper had died.

Barbara Keeley: We are really grateful. You have given such a full account. That is very helpful.

Chair: Thank you very much. We will come back to you shortly, Sue, if we may.

Let us now move on to our final witness from the family side. Joanne Hughes has been waiting patiently, and nodding vigorously at everything that Sue and Scott have been saying. Thank you very much for joining us, Joanne. Taiwo is going to ask you a few questions.

Q22 **Taiwo Owatemi:** Thank you, Joanne, for choosing to be part of this panel. I know how difficult today must be. Could you start by sharing with us your experience and the challenges that you went through in trying to find out what happened to Jasmine?

Joanne Hughes: In a nutshell, my daughter had a post-viral encephalitis. She had symptoms to do with that. At the time she was treated for it, it was clear to me that something had gone horribly wrong. She was at home. She was expected to go in to receive her treatment and then go home the next morning, and that process would repeat over three days. Instead, after she was given the treatment, her symptoms changed dramatically and she deteriorated significantly and very rapidly. She ended up being transferred to intensive care, where she subsequently passed away.

There was a 10-day period in intensive care before we let her go. I was raising concerns then about what had put her there and saying that it needed to be looked at. I was met with resistance even then. I was in a different hospital from the one where she had been given the medication; I had been transferred from the district general hospital to a tertiary centre. It struck me that there was no curiosity from the tertiary centre about whether something could have gone wrong with the care that put her there, yet there was massive confusion about what her illness was, because what had happened to her did not fit with the illness that they thought she had. It did not make sense to me that there was such a lack of curiosity, even then, about trying to look at the care to see whether that had contributed in any way.

As the other families have expressed, you cannot process what has happened until you understand what has happened. You cannot figure out how you are going to learn to live with loss until you understand why the loss has occurred, so that is your priority. I had already had 10 days in intensive care wondering whether I could put my trust in the organisations to be curious. After Jasmine passed away, I approached the trusts. As others have described, it was a question of my approaching them with my concerns, to ask them to be curious enough to look.

At that time, I was met very clearly with the opinion of the staff who had delivered the care. I should point out that I am referring to staff in the tertiary centre, because these are people who work in the most famous children's hospital in the world. I think there is a deference to their opinion that might not always be appropriate, because that relies on them having 100% insight into the whole picture, including everything that happened in the other hospital, and feeling psychologically safe to be open, particularly if errors have occurred in their care as well.

I wanted them to share my concern and my level of curiosity and to look properly. When it first happened, in 2011, I did not have the information, language or awareness that what I was asking for was a patient safety incident investigation. I was just asking questions, and I wanted to receive answers that made sense, or at least to see some effort made to establish those answers, as Scott described. That did not happen. Because it did not happen, because they were telling me that it was being put down to a very unusual presentation of my daughter's illness that nobody expected, but that, in their view, care had been appropriate, without my seeing any evidence that care had been properly assessed, at that point my trust eroded that there was an opportunity for collaboration between me and the trusts to establish reliably what had happened.

I had a need for an advocate. Sometimes we do not recognise that when people go to the legal system it is because they are looking for a person, not money. Certainly, that is what I needed. I needed a person who would take notice of my concerns, be curious, have methods of investigating those concerns and do something, at least, that was much more robust than what had been on offer from the trusts.

I also knew that I had an inquest coming up. I had had information from the coroner's officer that the trusts would be legally represented, either by their own in-house lawyers or by panel firms, so I had a need for a person there as well. I went to the litigation system for a person who could offer me the advice, support and advocacy that I needed both to try to establish the truth and to represent me at the inquest, which is naturally a very scary process to face alone as a bereaved family.

The upshot of the legal process is that it helped, in that I had representation at the inquest. I had independent experts review Jasmine's care and treatment. When they did, five different disciplines all found that I had been correct about what had actually happened when she was given her steroid medication. Basically, she had encephalitis, but she also had high blood pressure. When she was given the steroid, the blood pressure had shot up and that had caused what is called a hypertensive crisis, an acute blood pressure rise that then causes trouble in the brain. That is why she had suddenly deteriorated, started to seize and needed to go to intensive care.

What I had not realised until the legal process, until an independent expert reviewed everything, was that when she got to the tertiary centre, they had mismanaged her blood pressure too. That had resulted in 11 hours of hypotension, so she died of hypoxic ischemic encephalopathy and brain stem death because of lack of oxygen to her brain.

Both trusts had mismanaged blood pressure. The failure to monitor her blood pressure when she was given steroids had kicked off a chain of events that swiftly led to her brain stem death. It was made to look like an unusual presentation of the encephalitis that you would not expect to see.

I got independent expert opinion that gave me my truth, and gave me an explanation that made sense. It fitted with what I had seen. That was very helpful. The process gave me representation at the inquest, and it gave me the opportunity for those independent findings. However, the way the litigation system is currently set up meant that, while that was happening, the trusts obtained their own expert opinion.

I have investigated, and I have been fortunate to have people answer my questions openly about how that independent opinion was obtained. I know that the response by the trusts to the letter of claim, first of all, on the matter of blood pressure was simply the opinion of the treating clinician who was responsible for Jasmine's BP management when she arrived at the tertiary centre. I also know that, when they obtained expert evidence, they were selective in the documents that the experts viewed. One expert just copied and pasted the comments of the treating clinician with regard to the analysis of the element of the blood pressure management when Jasmine was starved of oxygen. The other expert, who was a BP expert, was asked very specific questions which meant that he did not even look at that area of care.

The claim was settled after exchange of expert evidence, when my experts could see all the flaws and the problems, and the fact that the correct narrative was not even understood by their experts. The claim was settled before there was any opportunity for their expert opinion to be scrutinised. The claim was settled on the basis that they did not acknowledge harm to Jasmine, purely because they held expert reports that had not been scrutinised. As a result, the good stuff that I obtained from the process was taken away.

The sad truth is that I "won", I was given compensation. All my clinical[1] costs were paid, but I felt devastation. The opportunity that the process gave for the trusts to choose not to acknowledge the harm that Jasmine suffered and just chuck some money at it was absolutely devastating and, I think, actually degrading.

If we had minor changes to the way things are done in the litigation system, we could avoid that sort of thing happening. I think we need more openness, transparency and fairness in what is given to the expert opinion providers, so that it is clear that they are starting with the same understanding of the narrative of events when they give their opinions on breach or causation. I also think that we should not have settlements where there is no explanation why. In my case, it would have been if we had had a settlement where an explanation was given as to why they felt a settlement was necessary, because that in itself was very confusing. I am not sure if I am allowed to go into figures, but I can tell you that my solicitors' costs were eight times the damages I received. I do not know how much the costs were on the other side, but I would say that overall the situation cost close to a seven-figure amount.

In those situations, when there has been no scrutiny of the reports but a settlement offer is made, the settlement offer should be made only with agreement on both sides of what the learning is from the case, or at least with the view that, considering there has been no scrutiny of the reports, the settlement does not prohibit scrutiny of the care afterwards. Then the good work that is achieved by claimant lawyers cannot be undone in that way.

Taiwo Owatemi: Thank you so much, Joanne, for sharing your experience. Before I hand over to the Chair, is there anything else you would like to tell us?

Q23 **Chair:** I have a question, Joanne, if I might, just to follow up what you said. Do you have any confidence that, in the trusts that you used and in the broader NHS, lessons have been learnt about not giving steroids to people with high blood pressure who have encephalitis?

Joanne Hughes: There are two key areas of learning to be found. One is, don't give steroids without monitoring blood pressure. I think they have grasped that.

The other one, which is more important, is about when you receive a child in a tertiary centre with a handover diagnosis, as Jasmine had, of suspected steroid-induced hypertensive crisis on a background of encephalitis. The mistake that was made was that the target blood pressure was set for the normal neuro-protection parameters of any child. It was not a personalised blood pressure target for that particular diagnosis. It has never been investigated as to why she did not get that personalised calculation. If she had, she would not have had 11 hours of oxygen starvation and she would have survived. That particular point has

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[1] Witness subsequently clarified that she meant legal costs not clinical costs.

never been investigated and has not been acknowledged. I see no evidence of learning.

Q24 **Chair:** The reason I ask the question is, what about the rest of the NHS and other trusts? Do you think that the lesson about Jasmine has been disseminated around the NHS?

Joanne Hughes: That, for me, has been the bugbear. There is no opportunity for that because the situation has not been properly understood, recognised and acknowledged by trusts.

How can I put this? There is opportunity because I have my expert reports, so I can go off and do all of that. I believe that it would be so much more powerful if I was doing it collaboratively with the organisations where it happened, particularly because one of those is one of the most famous children's hospitals, which would have huge influence on learning. I think it is a real shame. It is such a missed opportunity.

Q25 **Chair:** Thank you. We really appreciate that. You are welcome to remain part of the panel, if you would like, and apologies to those here in Westminster that the volume was very low, but we did hear you and what you said was so powerful that we couldn't not hear it. Thank you very much for sharing that with us.

I am going to move on to our expert witnesses. We are delighted to have, joining us remotely, Sir Ian Kennedy, who chaired the public inquiry into children's heart surgery at Bristol Royal Infirmary in the late 1990s and was chair of the Healthcare Commission. Thank you very much for joining us.

Dr Sonia Macleod is from the Centre for Socio-Legal Studies at the University of Oxford. Thank you for coming back.

Sir Robert Francis is chair of Healthwatch England, who chaired the public inquiry into the care provided at Mid Staffs.

Welcome to you all. I will start with Sir Robert, if I may, and ask for your reflections on what we have just heard.

Sir Robert Francis: First, I was grateful to listen to that. Sadly, those experiences are common. The messages I take from that, and from my experiences throughout my professional career as a criminal negligence lawyer, are that doctors, nurses and the system fail to listen to their patients and their families at the peril of the patient and, in the end, to the peril of the service as well. So much of what has happened, both in treatment that goes wrong and the aftermath of that, is that the first port of call is not, unfortunately, listening to the patient and the family about what has happened, and trying to understand it, but to use some preconceived notion. When something has gone wrong, the system we have, largely, I am afraid, because of the threats of litigation, results in a defensive attitude.

I am glad to hear that in one case we are not talking about a cover-up or indeed a lack of candour, yet all parties are thrown into an adversarial situation right from the outset, as soon as something might be a complaint or might be something that has to be referred to NHS Resolution, as it is now called. Sides are drawn up. What we have heard is that an investigation takes place behind closed doors. I suspect the question that is asked in those investigations is not, "What went wrong and what can we learn from this? What can we do better for our patients?", but, "Are we going to be liable?" That is not the question to ask. The question to ask is, "What happened, and can we avoid it happening again?" The answer to that might be very complicated, but the questions are simple. That is the first lesson.

The second is that litigation does not solve the problems, and was never designed to do so, although, as we have heard, some very talented and conscientious lawyers will seek to use the process for the purpose of learning. An adversarial litigation system always takes far too long to provide an answer, if it ever does, that is of use in learning to the system. As we have heard, the result that is often needed to litigation is financial support for very disabled people, and people who have been highly injured. That is a given, but the time it takes to get there will involve a struggle and, as we have heard, long periods of time when no such support is given at all. Why? Because of the adversarial nature of the system. Nothing happens to support someone who needs support before the resolution of the litigation. I think that is a disgrace.

The third point is about the time it takes to do things. As soon as you involve litigation it will take a long time.

Perhaps I ought to make one declaration before I start offering you an opinion. As you may know, I have been appointed to undertake a study into a compensation scheme for the victims of infected blood. I should say that anything I say here is nothing to do with that, and it should not indicate what I might or might not recommend there.

What we have heard is that we need a much better system, to avoid people feeling they have to litigate. In my view, that involves, first, looking again at how incidents are investigated. What has been said about HSIB is absolutely right. They cannot do everything, but their techniques should be widespread.

We need to do more than that. We need the same process whenever a result is unwanted or unexpected: looking into it, involving families and providing an explanation for what has happened, whether the family or the patient has asked for it or not.

Unfortunately, there are of course a huge number of instances and a significant proportion of those produce harm. Only a minority are actually looked into, and in probably only a minority are the family or the patient ever made aware that something has gone wrong. Until those matters are sorted out, and until there is a proper, objective and proportionate investigation to explain what has happened when something has gone wrong, we will continue to have a system that is not learning. We will continue to have a system where people who think something has gone wrong are forced into a system of litigation that is not designed to deliver for them what they want. I am sorry, that is a very long answer to your question.

Q26 **Chair:** No, no. Thank you. You are a lawyer. We will of course come back to you, but I want to ask Dr Macleod for her reflections on what we have just heard.

Dr Macleod: I absolutely echo a thank you to everyone who has spoken. It must be so difficult, but it is so valuable for us to hear. I completely agree with everything that Sir Robert said. The only thing that I would add is that, as well as an adversarial system at the moment, what we have is a very adversarial threshold.

The threshold by which we judge is individual error. I think if we moved away from looking at individual error to look at system-wide error, we should, hopefully, get, first of all, a system where people are prepared to acknowledge that, yes, something went wrong, whereas there is a reluctance to say, "I made a mistake." What we would, hopefully, get is a system where, instead of, as we heard in Sue's case, "One doctor made a mistake and that is our error," you would be forced to look at a wider system to say, "How did that happen? How was it that that doctor was in a position to make that error? Why didn't the system pick it up? Why didn't someone, when they were booking you in, say, 'Actually, hang on a second, you should not go home'?" As well as looking at the adversarial system, we have to look at the threshold we use to judge these situations.

Q27 **Chair:** Thank you. Let me bring in Sir Ian for your comments on what you have heard so far.

Sir Ian Kennedy: First of all, I would like to thank the father of Sam and the mothers of Jasper and Jasmine. It is very brave. It is very daunting to come and speak to a lot of people you do not know. What you say is immensely important and helpful, so thank you, and also commiserations.

My initial response, Mr Hunt, is that it goes on and goes on, and it is so awful and so sad. It should not need very good lawyers—you are lucky to get very good lawyers sometimes—four years to hunt things down or to get you, in Bethany's case, in front of people you can actually talk to. You should not need that, but that is what you are exposed to.

It should not need now for us to have to say, as Sonia Macleod said, that we have to look at systems. We have been saying that for centuries. When I did the Bristol inquiry, there was a way that children were taken from the eighth to the sixth floor, or from the sixth to the eighth floor—it doesn't matter—from where the ward was to intensive care and the operating system. That lift was so organised that, if someone got into it elsewhere and pressed a button before the people pushing the baby on a gurney got into the lift, you might find the baby taken down to the basement. That system is mad in terms of how you look after children, but no one gets on top of that because no one thinks in the larger scale of things.

My position is deeply radical. I have written about it many times. I would like to ask a question. Throughout what we have been talking about, there is a sense that something went wrong, and we need to look after the child in this case. But what if something did not go wrong and you got the same effect? That is sometimes how things work out. Why should we separate out what caused the problem? Why don't we focus on the problem, which is Jasmine, Sam or Jasper, and look after that child or patient? We can look after as many of them as are currently looked after in the NHS and with the necessary social care systems adequately, or inadequately, depending on staff and resources. Why don't we address their needs straightaway and then, on the other hand, look at what caused it?

The moment you separate out the needs of the patient and do not have to find someone to blame, or whatever, you can say, "That child needs that; we will do it," and then worry about how it came about. In the latter question, in my view you need a rigorous inspectorate, a rigorous regulatory system and a rigorous way of exploring.

I know, Mr Hunt, that when you were Secretary of State you were concerned with looking at Seattle and so on to see how they do it. We do not do it very well in this country. It is a regret of my life that when I chaired the Healthcare Commission, just as we were beginning to get a grip on collecting data and investigating, we were abolished, for a variety of reasons.

Separate the event and its effect from the cause of it. Worry about the cause of it separately and have rigorous systems to do so, properly financed. Meanwhile, look after the child. It does not matter whether it was someone doing something wrong, a system failing or just bad luck. The child needs the same and should get the same.

Chair: Thank you. I want to bring in my colleagues to ask some questions. I will start the debate and bring you in first, Lucy. I will put on the table some of the solutions that different people have proposed to the problems that Joanne, Sue and Scott were telling us about. As you are answering questions from my colleagues, I would be grateful if our expert witnesses could also reflect on whether they agree or disagree with those particular ideas.

One of our recommendations from our maternity safety investigation earlier in the year was that there should be easier access to compensation, as in the Swedish model where compensation is accessible on the basis of avoidability, not clinical negligence. Therefore, you would not have to go through a litigation process to get compensation if you were, for example, in Sue's position, providing the hospital agreed that something had gone wrong. That is one idea.

A second idea is that the amount paid should be based on NHS top-up costs and not wholly private provision, because that goes back a very long way to the time when the NHS could not provide as much care as it provides now. Another idea that has been floated is that there should be compulsory mediation before you start a litigation process, within a defined timescale, so that there is a process for bringing the sides together. Another thought is that there should be a much more rigorous independent investigation within a defined timescale, and the trust should be required to implement immediately any safety recommendations that arise from that investigation.

I do not want to say more because I will be accused of writing the report before we publish it, but I want to ask you to reflect on some of those ideas. Indeed, you might have more ideas. That is the purpose of this morning. I will hand over to Lucy now to ask some direct questions.

Q28 **Lucy Allan:** Thank you, Chair; I appreciate that. We have heard this morning about deference, complacency, lack of curiosity—"These things happen"—and lack of openness and transparency. Something that struck me hard was that Sue was a special adviser to the Secretary of State for Health, and Sue was able to fight and get compensation.

Sir Robert, you mentioned that many such cases arise, but that people are not in a position to do anything about it. I represent a constituency where we are awaiting the Ockenden review of maternity care and incidents like Sue experienced. Patients did not come forward until that review was launched. They were told, "This is normal. This happens. It's unfortunate." It was like Scott's situation with Sam, when he was told, "It's unavoidable. It's just one of those things."

In your experience, is it the case that people from a more disadvantaged background are going to be fobbed off with a story of complacency, deference and all the other things we have talked about, and that they do not have access to justice in the way that we would want them to have?

Sir Robert Francis: I think that is inevitably the case, but, if I may say so, my experience is that people from the most advantaged backgrounds can be just as lost and just as disempowered as the most socially and economically disadvantaged person. The reason is that, first, every one of us—93% or 94% in any poll—trusts doctors, and of course they should. They therefore believe what they are told. Of course, the doctors often believe what they are saying. The first point is that you believe the doctors.

The second point is that these things are very complicated. They require expertise in order to work out what has happened. Of course, very few of us have that at all. You are right that there is an absence of help for people. I am not talking about lawyers, but about help and support for people to whom unfortunate things have happened in a hospital.

Of course, there have been proposals before about advocacy and support, and some of them have been implemented or half implemented, but I am not sure that any of them ever got to the heart of it, which is that you need a supporter who is equipped, not necessarily a doctor, to ask the awkward questions that you might feel afraid or ill-equipped to do yourself. You need to be able to do that right at the outset.

Q29 **Lucy Allan:** Is Sir Ian right in saying that whenever there is an outcome that was unexpected the hospital should immediately launch some form of no-fault inquiry?

Sir Robert Francis: Yes. I think it is less than it used to be, to be fair, but part of the safety issue is that there is complacency—we have heard the word used—and the reassurance that it was "just one of those things." I am sure that in part it is bred by the fact that the apparent alternative at the moment is an admission that I personally, the doctor, was to blame for something when, as we have heard, so often the answer is a systemic one.

If the question is, "Was what happened avoidable?"—Sonia has mentioned this—and avoidable looking back at it now, the negligence test is all about the circumstances on the day and whether someone fell below a standard. You need to take that out of the equation and say, "Could it be avoided?" We should not tolerate things with unwanted results. We should not necessarily say that they are all avoidable, or were avoidable at the time, but if they are avoidable now why aren't we giving the support that should go with that?

In any event, as Sir Ian says, why aren't we proactively giving the support that patients and their families need at the time? The Swedish system, if we come on to that, works because there is an automatic assumption that anyone who has a social need gets, on the whole, a level of support that we can probably only dream of in this country. The first base is that, when something has happened, that is still part of the treatment that the patient should be receiving. Why isn't the support required given to the patient, and in the case of babies their families, straightaway rather than having to go to a lawyer to get it? That would be my first port of call.

Certainly in terms of disadvantage, you are right and I think the evidence shows, for instance, that those from disadvantaged groups fare less well in the complaints system as well. That is another bugbear of mine. Why aren't complaints that involve incidents not looked at in the same way? Equally, why isn't the system one that is involving patients straightaway by explaining to them, and having a duty to explain, even if the first explanation is, "We don't have a clue, but we are going to look into it"? There is a bit of reluctance to admit "We don't know," when with most things in the world we do not know until we have looked into things.

Lucy Allan: Thank you.

Q30 **Paul Bristow:** Before I ask my questions, I declare that my wife runs a communication consultancy that works with the UK Sepsis Trust and provides secretariat services for the all-party parliamentary group on sepsis.

A lot of what we have heard is focused on systems or a failure of systems, even perhaps a failure that a system does not exist to create mediation, understanding and learning. Sir Robert, to what extent do you feel that there is a cultural issue of circling the wagons when something begins to go wrong, or is it the fact that the culture creates the systems that are in place or the systems create the culture?

Sir Robert Francis: I think there are two parts to that question. The first, about systems, is that most people who work in the health service have very little understanding of or training—this is not a criticism—in the effect of systems on their behaviour and the work they do. Loosely, one would call it human factors. Because of the professional training that doctors and nurses have always had, in a laudable way they take on personal and professional responsibility for the work they do. When something goes wrong, they feel deeply that it is their responsibility. Frankly, the support is not often there to recognise that and to help them through what is often traumatic for them—not as much as for the patient—but there is limited understanding that the reason that what, in retrospect, looks like a stupid mistake was actually due to pressures that people have been put under. There can be all sorts of reasons. Sir Ian gave the example of the lift. No one seems to have thought that there was that sort of systemic issue involved. Equally, and topically, short staffing and the stresses and strains of working too long, of not having proper food and so on can all feed into someone making what appears to be a stupid mistake.

I think that ignorance about that starts with the reasonable and quite understandable feeling of personal responsibility for the work you do. The second part is that part of being a professional is that you work as a team, and teams stick up for their colleague. If you live in a culture where the end result of something going wrong is that someone is going to be blamed for it, you stick together. I believe there is a very strong culture in the NHS—probably not always consciously, but it is there—of, “We must defend our colleagues.” Actually, the best way to help one’s colleagues is, as a team, to work out what we could do better next time, to involve the patient in that and to make sure that the patient has been properly looked after.

The culture—again, litigation has its part to play in this—is, “If I say the wrong thing then I, if it is me, or my colleague, if it is them, may get into trouble with the employer or the General Medical Council, and we may find ourselves on the front page of a newspaper.” None of those things encourages candour. None of them encourages a learning atmosphere.

Q31 **Paul Bristow:** Dr Macleod, is that your reflection as well?

Dr Macleod: If we are looking at systems, we need to be really clear about what a system can and cannot deliver. If we are looking at clinical negligence as a system and saying, "What can it deliver?", the answer is that it can deliver compensation and it can deliver a finding on liability in an individual case. What it cannot deliver is making a hospital look at how they treated a patient, in terms of changing their practices. What it cannot deliver is an apology. Therefore, we need to be clear, when we look at systems and ask how they contribute to culture, about what that system actually delivers. What can it deliver and how does what it delivers impact on the wider culture? I think it is really important.

Sir Robert is absolutely right that there is a position not of defensiveness but certainly of support for colleagues. We have to look at that and say, "Okay, how do we change the systems that we have to minimise the barriers to coming forward and the barriers to open disclosure? What can we do to the system that would help to deliver the outcomes we want?" Part of that has to be saying, if we want culture change and open information flow and disclosure, do we need to look not at blaming individuals but at systems? If that is what we want to do, how do we embed that in the system that we have to deliver it?

Paul Bristow: Thank you.

Q32 **Laura Trott:** We have heard today how people have to resort to litigation to find out what has happened in cases. Sir Robert, you said that only a minority of cases are looked into. I feel that there has been a will to change this for a long period of time; indeed, I think I have read reports from both you, Sir Ian, and from Sir Robert that have recommended it. Why do you think that nothing has happened to date? I know we have made some advances, but why have we not seen the wholesale change that we have needed to see?

Sir Robert Francis: Sir Ian and I are part of the public inquiry chairs trade union, I suppose, and we are therefore used to making recommendations that are welcomed and then perhaps, when they are particularly awkward or challenging, buried, although not of course by the current Chair of your Committee.

Sir Ian is a pioneer and, among many others, has suggested a no-fault, no-blame system of compensation for many years. Sir Liam Donaldson looked at it as well. It has been talked about for many years, but nothing has happened. Part of it is fear that it would open a floodgate. Part of it is about the expense. I think all those points are decreasingly significant because we only have to look at how much it is costing now. We are not keeping the gates very firmly shut at the moment, and we are not decreasing the number of incidents that might qualify for compensation. The system we have is not actually addressing the point of resistance to a more up-front, proactive system of supporting people when things have gone wrong, in my view. I think that is one of the main reasons.

Q33 **Laura Trott:** Do you basically think that we need to make a financial case for this change?

Sir Robert Francis: I am not sure that the case has been made financially yet, to be frank. We do not know whether the experience here, if for instance we substituted an avoidability test for breach of duty, common-law negligence, would be a lowering of the threshold. The answer is that it probably would be. I think the answer is probably that you have to introduce other reforms that change the way in which we measure damages. That does not necessarily reduce the overall amount that people get in terms of what they need, but it may involve—I think Sonia mentioned this—the removal of the disregard for the availability of NHS care, so that you can claim for private treatment whether or not you could get the same thing on the NHS. Personally, I have long thought, and many do, that that needs urgent change. I think it was in your last report as well. That would make some difference.

If that is to happen, what is absolutely essential is that the state provision behind that presumption is there. I think there is a case, when the state, in this case through the NHS, has caused harm to somebody, for looking at what priorities should be given to the care and social support for such people. I think that is something that would need to be considered at the same time. The reason I say that is that in cases such as those we have heard about, when babies are damaged at birth and now have a very long life expectancy, inevitably they need hugely sophisticated care at home. A lot of it is labelled as social care, and the social care system finds it very challenging to cope with that.

The reason for multimillion pound damage settlements is largely, though not exclusively, the cost of paying for carers to look after hugely damaged children. I believe, therefore, that we will need a system where proper care could be provided through a state system before you will ever persuade litigants in that area to abandon litigation. Why would they, and why should they?

Q34 **Laura Trott:** Sir Ian, what are your views on the reasons why this has not happened to date?

Sir Ian Kennedy: I agree in large part with Robert. There are three things. First, there is a cultural barrier: the NHS is an icon and to admit the possibility of its fallibility in general terms is always very difficult. It is much easier to atomise the criticism, "Oh, that's over there in Shrewsbury," or, "That's over there in Bristol, but the NHS is still a wonderful thing." I am not for a moment saying anything other than that the NHS is a wonderful thing, except that there needs to be a capacity for objectivity and to say, "We need to look at what we deliver through our healthcare system, and it is not always up to snuff."

The second thing is a question of justice. I do not think we have wrestled with the question I posed earlier, namely that there is a question of justice or fairness in identifying some people who will be well looked after, as Robert says, with social care as well as healthcare because of the way their harm was incurred. We do not have the same view on someone else who serendipitously cannot point to anyone as having broken any duty but it just happened. The issue of justice there is apparently too difficult to confront, so we have a bifurcated system where unfairness runs through it.

Thirdly, Robert, I and others, have always been concerned that money is proposed as the real problem. Robert talks about damages. I think more helpful language is the cost of care, for both healthcare and social care, and social care as it is currently organised means that it may not be available to some. That needs root and branch addressing so that, whatever the cause, the state is able to provide it.

I venture to think that it would not cost as much as the current litigation system, bearing in mind that the current litigation system also leaves the child in Alder Hey, who was recently awarded £27 million in damages, without any additional financial support for 11 years. I venture to think therefore that the costs can be organised and analysed in such a way that we can show that it is worth paying for. As to whether it will be less than the current system, it certainly may be less in money terms, and it will certainly be better in justice and fairness terms. Let's not put the financial barrier in front without looking at it and, in looking at it, obviously the criteria you use will determine what end result you arrive at.

Q35 **Laura Trott:** Sir Ian, of those three points, on the financial side of things, you have proposed how we could overcome this and move forward. On the cultural barriers and the elements of justice that you discussed, what can we suggest as a Committee? I think the last thing we all want to do is to produce something that says we need to change the threshold, investigate individual issues and move to top-up costs, and then it just sits on the shelf and nothing happens. How do we change those other two points as well so that we ensure that we are making the system changes that we have all talked about today?

Sir Ian Kennedy: I wish I had longer. Cultures are pretty difficult to address. Some people say that you have to change practice to change cultures; other people say you have to change cultures to change practices, and because they will not agree and it is all too difficult nothing ever happens.

Let me give you one idea. Robert has talked about this, as has Sonia to a degree. Those who lead trusts—I do not know whether Barbara Keeley's experience would tie in with this—have very rarely been trained in notions of leadership. That sounds odd, but they usually come up through a managerial trail of finance or workforce or whatever. The notions of leadership that the Army, for example, is interested in have it as an understanding that they are there for a purpose, and that you can inspire the workforce that you lead to look at the world in which they work in a particular way.

That particular way would be that we are there, first and foremost, for patients. For example, as GPs we do not have office hours, because patients do not get ill only between nine and five. In hospitals, we do not have a complaints manager because that means all the rest of the staff say, "If you've got a complaint, go to George or Josephine." Everybody there should realise that they are there for patients. We should not have a patient safety officer because every person in the institution is responsible for safety. They need a leader who can persuade them that that is what they are there for.

You and I know that no nurse or doctor leaves home every day saying, "I'm going to hurt a patient or ignore a patient." They do exactly the opposite, but then they find themselves trapped in a culture that does not reward or incentivise that kind of behaviour, but does the opposite.

I am hogging the microphone but I will tell you one story. When we did an inquiry into a hospital in Tunbridge Wells, there was a little elderly lady who wanted to go to the lavatory. She was in one of those big Nightingale wards. She rang her bell, but nobody came. She rang the bell a bit more urgently, but nobody came. This was public—in the published transcript. She rang the bell again, and a nurse came to the top of the ward and said, "Go in the bed, dear. I'll be there later."

It is difficult to think of a more awful thing to be told. The immediate reaction of course is, "That nurse's feet should not touch the ground before she is out of the building," but that is to not understand the circumstances she was under. They are understaffed and under pressure to do x and y. There are not enough people to help out. All of those were facts in the case. Therefore, it was opting for an awful solution, but there might have been more awful solutions if she did not go immediately to where she was supposed to go. Unless you understand that you have to help the workforce and get them to realise that everybody is important to them, and then make sure that the workforce is organised to do so, you are going to have the tragedies that we have been hearing about today.

Laura Trott: Thank you.

Q36 **Barbara Keeley:** I have a question about the time it takes to get things done. It seems to me that one of the most aggravating aspects of the stories we have heard is just the sheer time it takes.

Sir Robert, you have talked about a better system to avoid people having to litigate. What about hospital trusts that are complacent, as Sue has told us? If the system cannot make a hospital change its culture to live with the awful results of that terrible care and the mistakes that were made across such a period of time, it just makes the whole thing worse, doesn't it? Without litigation, it took Scott six and a half years to get to the truth and what other things could have been done. Even Sue's experience, with what sounds like a good team, took four years.

What can we do about that? That seems to be one of the most negative and aggravating things we have to deal with.

Sir Robert Francis: First, it would be only fair to acknowledge that NHS Resolution has been seeking to introduce schemes that bring forward the possibility of examining things properly through what was the rapid resolution scheme, now the early notification scheme. I think it is in obstetrics only, but they may be thinking of making it wider, whereby they require trusts to notify them very early, within weeks, if not days, of an incident that might give rise to those sorts of issues.

I have had professional experience of being involved in at least one such case, and the speed at which it is possible to gather together a team of experts to talk to the family about their concerns, to be quite transparent with them about what is being looked into, to meet all the relevant doctors and nurses, to come to an early expert view as to what the situation was and to be able, first, to explain that to the family and, secondly, immediately, where it is appropriate, to start looking at what compensation or support they need is a remarkable thing to witness. When it happens and it works, the family retain their trust for the system and the doctors. In the case I was involved in, where, frankly, terrifying mistakes were made leading to a tragedy, the bereaved family were still sending Christmas cards to the midwives. That was the level of trust involved. Something like that works.

Obviously, it requires a level of resource, but at the end of the day there is undoubtedly a business case because you are demonstrably saving legal costs. At the moment, so much of the work that has to be done in litigation, preparing for a claim, has to be done by the claimant's lawyers, who have to instruct experts, often starting with a blank piece of paper, and struggling to get the records and all the rest of it. If there was an obligation on the system to do all that work up front in an honest, open and transparent way, most of these cases could be solved very quickly indeed.

Q37 **Barbara Keeley:** In what proportion of cases do you think that is happening? It is very good to hear that, but we heard this morning from—

Sir Robert Francis: Sonia may be able to help you more about the proportion of cases. I do not think it is as large as it should be, and obviously there are resource implications attached to it. You should ask NHS Resolution for the answer to that. All I am saying is that, from personal experience of seeing it work, when it does work, it is something to explore.

Mediation has been mentioned, and we have heard of a successful case of it. We are slightly assuming that, when this has happened, everyone agrees. Of course, that is not what happens in real life. You need a proper, mediated discussion to come to an outcome. That is where mediation and conciliation techniques come in. At the moment, they happen too late in the process, after a great complexity of litigation and the litigation process has started.

If you put a mediation technique in right at the outset, when there are angry people on one side and scared doctors on the other, that is exactly the sort of situation where trained mediators and conciliators can have an enormous effect on getting people to focus on the issues and to come to an outcome that is mutually satisfactory. I suggest that is something that needs to be looked at. That again requires resource up front, but you are investing in avoiding litigation costs. Those would be my two suggestions.

Q38 **Barbara Keeley:** Dr Macleod?

Dr Macleod: If we look at how we could possibly do things differently, and look at international models, in the US there are two states that have birth injury compensation schemes—Virginia and Florida. In Virginia, eligibility for compensation is determined for every single child entered on that scheme within four months of the scheme becoming aware of it. In Florida, every single child with eligibility for compensation is determined within eight months. What that shows is that it can be done. That is not the experience we have here.

Resolution are working really hard with early notification, but they are not hitting anything like those targets. It can be done if you think about it slightly differently. What they have done in those schemes is to put much more factual criteria in place. They said, "Was the child delivered in a hospital that is covered? Was the child over 2,500 grams for a singleton?" They vary slightly between them, but in essence does the child have a physical or other neurological complication from the birth? If they do, they are in the scheme. It is that simple and it works that quickly. It is much less adversarial.

I absolutely agree about putting alternative dispute resolution right at the front of the process. I would be a bit more radical on mediation. I would go for a more inquisitorial investigative model, a bit more like an ombudsman. If you are in mediation, you still have the adversarial two sides. I would prefer to see, as I say, an ombudsman inquisitorial model at the front because it takes out the adversarial nature from the get-go. If that does not resolve it, potentially go on to litigation. That would be one route that might help.

Chair: I am going to come back to our three families and ask at the end if they would like to make any final comments, or have any particular questions to ask the expert witnesses. Before that, Dean Russell.

Q39 **Dean Russell:** I thank the families for such powerful testimony today. The question I have, if I can come to you first, Dr Macleod, is around compassion in the system. We often talk about systems and clinical processes, but at the heart of all this are grieving families or families adjusting to something that they never expected, especially when it is around births, and a moment that will stick with them forever.

I wondered if there was any guidance on what we should be doing within the litigation process, in the first few days and months, around mental health support and compassion, so that people do not feel that they are adversarial or that they are the enemy of the system in having to bring up these complaints, but that they are fully supported.

Dr Macleod: If you are looking at the litigation system, you have to bear in mind that by the time someone goes to a lawyer they have usually had a bit of time. People do not go straight from the hospital where the incident occurred to the lawyer's office. They simply do not.

Of the people who contact claimant lawyers with a potential concern, about 95% are filtered out. What we see going through to cases is actually a very tiny minority of the concerns that people have and that they have raised with lawyers. There is clearly a need to address the concerns people have, and much earlier in the process. I do not think that is something that the clinical negligence system, as it stands, can address because it is reactive, in that it waits for someone to go to a clinical negligence lawyer.

If you look at other countries and patient injury compensation in Sweden, for example, what happens in a lot of cases there is that the doctor or nurse will sit down with the patient in the hospital and say, "Look, there has been a mistake," or, "Something has gone wrong. We will sit down with you and fill in the form with you." There are advocates in each hospital who do that, so that the claim for compensation goes through with the support of the staff. That happens partly because it is on an avoidable basis, so staff do not feel blamed. It also leaves patients in a position where they are cared for from the outset rather than almost abandoned and left to find their own route through.

Q40 **Dean Russell:** Sir Ian, you mentioned the example of the lift going down to the basement rather than up a floor and so on. One of the things that occurs to me is that whenever there is an awful situation—as with the testimonies we have heard—you often then hear that there were smaller examples of near misses or other issues, with the lift being a good example.

Is there a role beyond the examples we have heard today for a root and branch review of how patients can feed in their experiences within hospitals and the healthcare system, either through technology or surveys, so that the smaller issues are picked up that might then lead to the bigger issues coming down the line that no one has noticed?

Sir Ian Kennedy: There may be. Patients are experts in some things, particularly their own lives and their own expectations, but they are not necessarily experts in how the hospital works. They are often bewildered by it.

Yes, of course, stepping back a little, in my view—I agree with Sonia to a degree—there is a role for a regulator, inspector or ombudsman, whose job it is to collect data. The key is what data you are seeking to collect. One of the important sources of data is complaints or observations, or even compliments. A good regulator, if we could even design one, would collect that data and have it collated with lots of other data to understand how that particular enterprise, whether it is a GP practice, a trust or a world-famous tertiary centre, is working and what the range of problems is.

A good regulator, as I was trying to create, would be quite active in scanning that data and having appropriate algorithms to mine it. They would say, "You are beginning to have a problem here." If the hospital said, "No, we don't," then they have a problem and you would have to look at it. If they said, "Yes, we cannot recruit some nurses in that particular area," the regulator would say, "All right, we'll stay with you, and see if we can help you and stay on the case."

You are absolutely right that these apparently minor events can be seen in a context. The context is one in which things, in the great systems analysis, are like Swiss cheese. You get through one hole and another hole, and at one point you get right through the cheese and then something awful happens. If you could spot the first hole with a good inspectorial ombudsman or regulatory system, with good data, you are beginning to help patients.

Q41 **Dean Russell:** Thank you. Sir Robert, many of these cases are isolated in some instances, but earlier you mentioned the learning process. How much learning is there in the system? Often, when we have had big reports when there have been major issues at hospitals, there are reviews, inquests and all those things that ultimately are learnt by the system. Every time there is a situation like this, when there is litigation, does the entire NHS learn from it, or is it just, "That's it," and they breathe a sigh of relief that it is done with and they move on to doing the day job again?

Sir Robert Francis: I think the answer is somewhere in between the two. NHS Resolution instructs its lawyers now to draw safety-related information out of cases, which they will report back to the trust. They publish reports, as do the medical defence societies, which talk about generic lessons to be learnt.

None of that seems to me to be done on a terribly systematic basis. It is a little bit haphazard. Frankly, with all due respect to my legal colleagues, your average medical negligence lawyer, whether a solicitor or a barrister, is not necessarily the best equipped person to decide what the safety learning should be in relation to a particular incident. That is not what we are trained to do. We rely on other people's evidence. Relying on litigation to provide the answer at the moment is hopeless, frankly, because of the time litigation is taking. I do not think that is the answer.

If I could go back to complaints, I think there is learning there. I will put my Healthwatch England hat on, if I may. We published a report called "Shifting the mindset" last year, which did a survey of hospital complaint systems and what they do. I am afraid that a large proportion of them are not even obeying the minimum statutory requirements for reporting complaints. Many only report numbers. Very few report more than a category of complaint. Virtually none, though there are some, tell the stories from which there could be generic learning. There is a huge resource of information from complaints that is not being used.

One can add to that, if I can get on to my hobby-horse, the information that comes through the friends and family test. There are figures and we can calculate the numbers, but there is a huge amount of data in textual comments. For instance, we at Healthwatch England have no access to those because of data protection requirements.

Chair: I think Sir Ian wants to come in on that point as well.

Sir Ian Kennedy: To add to what Robert said, one of the ways in which you can ensure that the lessons that have been demonstrated here can be disseminated is that you make them a standard that the regulator judges performance against. If you make one of the standards the extent to which you have incorporated in your practice what has been demonstrated to work in Hull, or avoided what has been shown to be mischievous in another place, you will have to report on that, and that data will be collected as part of the performance against standards. That is the way you do it. As Robert and I know, if you do not measure it, it does not get done.

Q42 **Chair:** Thank you. We need to draw things to a close, but I want to go back to our families to give them a chance to have the final word. We will start with you, Joanne, if we might. Do you have thoughts or comments about what you have heard this morning?

Joanne Hughes: Yes. First and foremost, I want to share that not only am I someone who had a personal loss but I have worked across the system to try to see change for nearly a decade. Included in that, I have undertaken training in restorative practice. I understand the values and principles of that approach. I think a lot of what has been talked about here on culture change means that we need more people within the system to understand the restorative response to harm. Then we will start coming up with some more sensible solutions. I am just about to complete my training to be a mediator, so I see the difference between what proper mediation is and the mediated settlement amounts, which are two very different things. I wanted to share that I have that sort of background.

Of course, I appreciate the focus on birth injury, but we need to recognise that these situations result in all sorts of outcomes. Ultimately, if you take the restorative approach, harm has occurred. The response is, “Who is hurt and what do they need?” It might be the baby. It is also the parents. It is also the staff involved in what has happened. It is the wider organisation. All those people have needs that have emerged from the fact that the harm has occurred. Then you look at the obligations around that need. You start looking at who the players are and what they need to do for the people who have needs to get them met.

One of the big, important things in that process is how we restore trust and confidence, and the relationship and wellbeing of all those people. You cannot learn without restoring trust, confidence and wellbeing of the players, and if there hasn't been acknowledgment of the harm caused in the particular case. I think that gets overlooked. It is really important; if there is no acknowledgement, the moral injury that staff, patients and families have suffered that needs repair through acknowledgment and apology cannot happen. What that creates is situations where people cannot sleep at night because they know that something has been settled and something has been learned internally, but they know that the family does not really know the truth and the wider learning. They have not had the opportunity to properly apologise. I think that is important.

Within a restorative process you ask, "Who has been hurt? What do they need? Who had a role in the harm?" It recognises not that people are to blame, but that there is collective responsibility. It takes a systems focus. "Who had a role in the harm and what are their obligations?" That is around explaining, giving the context and all the things we talk about in a systems focus. "Who has a role now in repairing the harm? How do we restore trust and confidence in the relationships? What do we do to prevent this from happening again?"

Crucially, that process, and the people whose incident it is, belongs to the staff, the patient and the family, and they have a really strong voice in the process. If we had more people, right from the very top to the shop floor across the system, and patients and families, understanding what a restorative process does, which is needs analysis and meeting needs, for the NHS, which is all about meeting the needs of suffering people, it is a very complementary process. I think it supports the just culture. We do not need a just culture; we need a restorative just culture. I think we could have a litigation system that aligns itself nicely with that, if we started with that as our starting point.

Q43 **Chair:** Thank you. After what Sir Robert said, we might call it the Christmas card test.

Joanne Hughes: Exactly that.

Q44 **Chair:** Thank you. Scott?

Scott Morrish: You posed four questions earlier. It would be really nice, and it would be kinder and perhaps more humane if compensation could be addressed quickly and early, without the need for any other process, either complaint or litigation. It seems practical and sensible to base costs on the NHS rather than on private healthcare. That is just a personal view.

It is staggering that mediation is not there already, but it is not for most people. It should be there. It should be a compulsory part of the aftermath of any harm event.

One word of warning. On the idea of timescales for investigations, which I think you mooted at the beginning, I was given an investigation report on the day that it had to be done so as not to be late, but it was completely wrong. What you need is a good and comprehensive investigation, one that includes all of the voices, be they from the family side or the staff side, and not just a responsible clinician or the chief executive. Timeliness is somewhere down the pecking order if you are going to think about it in those terms.

The idea of whether practice changes culture or culture changes practice was mooted, as was the idea that culture might change the system, or the system might change the culture. We get the culture we regulate for. We can tinker with clinical negligence, but if we do not actually address the malfunctioning nature of regulation as it is right now, its siloed nature, and regulate for the behaviours that we want and have been hearing about all the way through this, including from Joanne just now, we will not get what we want. At the same time, you have to regulate against the behaviours that you do not want. We need to start seeing people punished and blamed for a cover-up. We should not be squeamish about the word "blame". It is inescapable. The question is: what do we do with it, and when do we use it? Is it used sensibly?

Another thing, to end with, is that there is a drag created by litigation and by complaints processes. It traps everybody involved for a ridiculous period of time. It has lots of negative consequences, not just emotional and psychological. It strains marriages. It takes people out of work. I would have been fired if I had a job, but I am self-employed so I get away with it.

At some point, the bullet needs to be bitten. The wider harm that is caused in historical and unresolved cases needs to be addressed. There is a drag created by that which permeates everybody's thinking. It feeds into the sometimes blame culture and sometimes defence culture. It also allows complacency to sit just under the radar. I will stop there.

Q45 **Chair:** Thank you. Sue?

Sue Beeby: There are two things from me. There are reasons behind why people choose to litigate against a hospital. One of them is clearly our original reason, which was to pursue some kind of damages for Jasper so that he would be financially supported through the rest of his life. Changes in that system, allowing money to be given earlier than it currently is, would be better for both the patient and the hospital, as I mentioned before, because you have better outcomes as a result. That is definitely something that needs to be looked at.

The second thing is about understanding what happened. These are really traumatic events with individuals at their heart. For parents like us sat here, all we ever wanted was to understand what had happened to our child and why something so horrific had been allowed to occur. Being able to make sure that the person is heard within the process is really important.

Mediations up front would be really helpful. Our case would have stopped when Jasper died, had that been the case, but because we had never had the opportunity to sit down and properly understand what had happened and be heard, it continued for another two years, perhaps unnecessarily. I think they are the sorts of things we need to take from this.

In the NHS now we have, "No decision about me without me." That has to be the same when harm happens, to ensure that the person who has been harmed or hurt, or their family, is central to the process and that it is not something that happens behind closed doors. They should have the opportunity to have their voice heard.

Chair: Thank you. That draws things to a close. I thank our expert witnesses for their excellent testimony—it was very helpful—and obviously particularly our three family witnesses, Joanne, Scott and Sue. We are very conscious that you have come today out of a sense of duty to Jasper, Jasmine and Sam. The truth is that we need a system that is a thousand times better at learning from the kind of tragedies that you went through. In order to get that, you have all been willing, not just here but I know in all cases on many other occasions, to relive the sadness that your families went through to try to make sure that it does not happen to others. Thank you very much for that. Thank you everyone for coming this morning. That concludes the session.